



MEDICAL REFUSAL LETTER BY MEMBER

Date: _____

To whom it may concern:

RE: INSURANCE MEDICALS REQUESTED FOR GROUP RISK

NAME OF FUND: _____

I do not wish to attend to the medical requirements as requested by the insurer of my group risk benefits. I have been provided with the information, limitations, potential cover details and medical requirements.

I fully understand that my benefits will be limited and the implications and consequences thereof.

Signed at _____ this _____ day of _____ 20 _____

FULL NAME

SIGNATURE OF MEMBER

ID NUMBER

SIGNATURE OF WITNESS

NAME OF EMPLOYER

AUTHORISED SIGNATORY OF EMPLOYER



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