



MEDICAL REFUSAL LETTER BY MEMBER



Date: _____

To whom it may concern:

RE: INSURANCE MEDICALS REQUESTED FOR GROUP RISK BENEFITS UNDER THE SETSHABA PROVIDENT/PENSION FUND (delete Fund not applicable)

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

