the gpaa
Department: Government Pensions Administration Agency
REPUBLIC OF SOUTH AFRICA

GOVERNMENT PENSIONS ADMINISTRATION AGENCY

Z583 MEDICAL SCHEME MEMBERSHIP

GPAA USE ONLY - GPAA STAMPS

Z583 MEDICAL SCHEME MEMBERSHIP

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PARTICULARS OF MEDICAL SCHEME MEMBERSHIP

This form is used to process the application for continued Medical assistance or to indicate a change in Medical Scheme Particulars

TYPE OF APPLICATION: Select under Section A
COMPULSORY ATTACHMENTS : See section B

A) TYPE OF APPLICATION - Please select only one option

☐ 1. Application for continued Medical Assistance after Retirement / Death in Service (Resolution 3 of 1999 and Resolution 1 of 2006)(*compulsory items : B, D, E, F, G, H, J and K.* ***Also C in the case of a death in service***)

☐ 2. Continued Membership of a Medical Scheme – Change of Medical Scheme Particulars
(compulsory items : B, C, D, E, F, G and K)

☐ 3. Application of Widow / Widower for continued membership of a Medical Scheme
(compulsory items : B, C, D, E, F, G and K)

B) COMPULSORY ATTACHMENTS

All copies of ID documents should be clear, and should not be older than 6 months.

1. Certified copy of ID of the main member of medical scheme		***Only applicable to Type 1 applications***	
2. Proof of dependants registered on your medical scheme		*1. Copy of last Salary advice*	
3. Membership certificate from current medical scheme		*2. Completed Z894 Bank Particulars*	
4. Member death certificate (if applicable)		*3. Service Certificate*	
5. Please include previous medical scheme certificate(s)			

C) PERSONAL PARTICULARS OF DECEASED MEMBER

Pension Number

Surname

First Name

Middle Name

Maiden Name

Title Init D.O.B ID No

Date of Death Marital Status ☐ Married ☐ Unmarried ☐ Widow/er ☐ Divorced ☐ Life Partner

D) PERSONAL PARTICULARS OF APPLICANT

Pension Number

Surname

First Name

Middle Name

Maiden Name

Title Init D.O.B ID No

Income Tax No Marital Status ☐ Married ☐ Unmarried ☐ Widow/er ☐ Divorced ☐ Life Partner

E) CONTACT PARTICULARS OF APPLICANT

Postal Address

Postal Code

Tel No

Residential Address

Postal Code

Cell No

E-Mail

ALL PAGES OF THIS FORM MUST BE COMPLETED IN ORDER FOR THIS FORM TO BE VALID AND THE MEMBER OR PENSIONER AND COMMISSIONER OF OATHS MUST INITIAL THIS PAGE.

Member/Pensioner initial

Commissioner of Oaths initial

Pension Number

F) PARTICULARS OF DEPENDANTS - For any dependant registered on your medical scheme

	Surname	Initials	ID Number	Type *
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

* 1-Spouse 2-Child 3-Disabled 4-Student 5-Life Partner 7-Mother 8-Father 9-Grandchild A-Sister B-Brother

G) PARTICULARS OF THE CURRENT /NEW MEDICAL SCHEME

Medical Scheme Name

Plan Name

Medical Scheme Number

Would you like to continue your membership? Yes ☐ No ☐

Date of Benefit

Membership Commencement Date

H) PARTICULARS OF THE PREVIOUS MEDICAL SCHEME

Medical Scheme Name

Plan Name

Medical Scheme Number

Date membership terminated

I) CHOICE FOR MEDICAL BENEFIT UPON RETIREMENT / DEATH

A single choice between Option A or Option B is compulsory - Please indicate clearly

1. OPTION A - Continued State Subsidised Membership ☐

Subject to 12 months continued membership of a registered medical fund on the last day of service and previous government service exceeding:

- 15 Years in respect of retirement
- 10 years in respect of medical discharge

Employer Name

Start Date End Date

Employer Name

Start Date End Date

Employer Name

Start Date End Date

Employer Name

Start Date End Date

OR

2. OPTION B - Gratuity Payment (Once-off cash amount) ☐

Subject to 12 months continued membership of a registered medical fund on the last day of service only if less than:

- 15 Years in respect of retirement
- 10 years in respect of medical discharge

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J) TO BE COMPLETED BY THE LAST EMPLOYER DEPARTMENT

State Contribution to member medical aid on last day of service

Last day of employment

Reason for retirement

Service record in government departments or related institutions. All periods of service must be furnished:

From	To	Department or Institution

I certify that all particulars in this form are true and correct.

Official Date Stamp of Employer

Signature

Designation

Surname of Employer Representative

Tel No

Fax No

E-Mail address

K) CERTIFICATION PARTICULARS

I declare that all the particulars furnished on this form is true and correct.

Signature or Thumbprint of Member

Date

Declared and signed before me

Commissioner of Oaths

Date

Commissioner Stamp

By submission of the Z583 form the member/pensioner/applicant confirms that the information provided therein is true and correct and authorizes the GEPF/GPAA to process his or her personal information in compliance with the Protection of Personal Information Act, 2013. Please refer to the GEPF and/or GPAA Privacy Policies on the websites www.gepf.co.za and www.gpaa.gov.za.