

MEDICAL REPORT (CONTINUED)

Treatment and medication required:

(Attach detailed quotation from medical practitioner or service provider – compulsory.)

Horizontal lines for text entry.

Member’s motivation (compulsory):

Horizontal lines for text entry.

Doctor’s name

Grid for name entry.

Signature

Line for signature.

Practice number

Grid for practice number.

Date

Grid for date (DDMMYY).

TO BE COMPLETED BY EMPLOYER/PENSION FUND ADMINISTRATOR

Should the pension fund administrator be unavailable, a copy of a recent pension slip will be acceptable.

Name of company

Grid for company name.

We confirm that

Grid for confirmation text.

is/was employed by us and

receives/received a gross salary/pension of R

Grid for salary/pension amount.

per month.

Length of service with company: Years

Grid for years.

Months

Grid for months.

Recommendation by employer:

Horizontal lines for text entry.

Signature

Line for signature.

Large box for company stamp.

Company stamp

Name

Grid for name.

Designation

Grid for designation.

Date

Grid for date (DDMMYY).

TO BE COMPLETED BY MEMBER

	MEMBER	SPOUSE	TOTAL
Gross salary			
Gross pension			
Other income			
Total			

Total deductions Total net income

Monthly expenditure R

Bond/rent R

Municipal rates and taxes R

Electricity and water R

Telephone R

Hire purchase payment(s) R

Please specify:

(a) R

(b) R

(c) R

Insurance premium(s) R

Transport R

Domestic and garden help R

Groceries R

Clothing R

Other R

Total R

Net income R

Expenditure R

Net cash surplus/deficit R

I, , the undersigned, hereby certify that the information stated in this document is true and correct.

Signature _____

Date