OMSMAF
OLD MUTUAL STAFF MEDICAL AID FUND
Healthcare with heart

Administered by Universal Healthcare (Pty) Ltd
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PLAN SELECTION FORM

FOR ACTIVE EMPLOYEES WITH ACCESS TO WORKDAY, PLEASE MAKE YOUR PLAN CHANGE VIA WORKDAY ONLY.

Please complete this form **digitally** or in **BLOCK LETTERS** using black or blue ink. Only complete and return this form if you require a Plan change. **Should you choose to remain on your existing Plan, you do not need to submit this form**. Please complete and submit this form by no later than **06 March 2026**.

This form must be signed by the member and forwarded to:
E-mail: membership@omsmaf.co.za
Call Centre Number: 0860 100 076

MEMBER'S DETAILS

Surname

Name(s) | Staff code

Email Address | Membership number

Contact numbers (H) | Cell

Contact numbers (W)

YOUR CHOICE OF PLAN

Indicate your choice of Plan by selecting the appropriate block below

- ☐ **Hospital Plan**
- ☐ **Savings Plan**
- ☐ **Network Plan****
  (not suitable for members in Namibia or outlying countries)
- ☐ **Traditional Plan**
- ☐ **Network *SELECT* Plan*****
  (not suitable for members in Namibia or outlying countries)
- ☐ **Traditional *SELECT* Plan***
  (not suitable for members in Namibia or outlying countries)

Members choosing one of the SELECT Plans above are restricted to using the SELECT list of hospitals (see back of the member guide/ online look-up tool). A co-payment of 20% of the total hospital bill will apply if you choose a SELECT Plan and then voluntarily get admitted to a hospital that is not on the SELECT list of hospitals. In view of this, the SELECT Plans are generally not suitable for members in Namibia or outlying countries.

** Members choosing the Network or Network SELECT Plan must please check with Universal Healthcare regarding the GPs, dentists and optometrists available to them via the Universal.one app or emailing network.accounts@omsmaf.co.za.

MEMBER DECLARATION

I have read and fully understand all the information provided regarding the structure of my chosen Plan.
If I have chosen one of the Network or SELECT Plans, I confirm that I have read, and that I understand and accept the restrictions of this Plan and the co-payment implications if I do not comply with such restrictions.

Signature

Date D D M M Y Y Y Y

If you do not have access to a scanner and printer, you may type your name and email the form.