

**IMPORTANT NOTE:** Please note that this GP Nomination Form must be completed in full and emailed to [changemygp@primecure.co.za](mailto:changemygp@primecure.co.za), or call the Prime Cure contact centre on 0861 665 665. Upon approval, confirmation of change will be emailed to the requestor within 24 hours of receipt.

## A Principle Member/Policyholder Details:

Surname:

First Name:

ID Number/Passport:  Cell:

Tel:  Fax:

Email:

Member/Policy Number:

Medical Scheme/Health Insurer:  Medical Scheme/Health Insurer Plan:

Employer:

GP Practice Name:  GP Practice No:

GP Practice Name:  GP Practice No:

Member Signature:  Date:

## B Dependent Details:

Should you have more than three dependants please complete a second form and submit the forms together.

1. First Name: <input type="text"/>	Surname: <input type="text"/>
ID Number/Passport: <input type="text"/>	Dependant Code: <input type="text"/>
GP Practice Name: <input type="text"/>	GP Practice No: <input type="text"/>
GP Practice Name: <input type="text"/>	GP Practice No: <input type="text"/>
2. First Name: <input type="text"/>	Surname: <input type="text"/>
ID Number/Passport: <input type="text"/>	Dependant Code: <input type="text"/>
GP Practice Name: <input type="text"/>	GP Practice No: <input type="text"/>
GP Practice Name: <input type="text"/>	GP Practice No: <input type="text"/>
3. First Name: <input type="text"/>	Surname: <input type="text"/>
ID Number/Passport: <input type="text"/>	Dependant Code: <input type="text"/>
GP Practice Name: <input type="text"/>	GP Practice No: <input type="text"/>
GP Practice Name: <input type="text"/>	GP Practice No: <input type="text"/>