



Vat Reg No. 4790185997
 Practice No. 0126225
 P.O. Box 7344 , Centurion , 0046
 Block A, Arena Office Park, West Avenue ,
 Centurion

Please complete this form and fax it to **0866 11 4000/1/2/3**
 Please dial **08600 27 800** if you need to speak to a customer service agent
 Assistance is also available on www.pharmacydirect.co.za

Principle Member Information

Initials 1st Name Surname Pensioner

ID No. Medical Aid No. Yes No

Medical Aid Option

Tel Work Home

Cell E-mail

Patient 1 Information

Initials 1st Name

Surname

ID No. Gender M F

Doctor

Tel

Patient 2 Information

Initials 1st Name

Surname

ID No. Gender M F

Doctor

Tel

Address Detail

Home/ Physical Address

Building Street & No.

Suburb Town/ City Postal Code

Postal Address (If different to home)

Line 1 Line 2

Suburb Town/ City Postal Code

Work Address

Building Street & No.

Suburb Town/ City Postal Code

Please Deliver to my: Work Postal Address Home (Only if someone can receive parcels)

Service Required

Please deliver my medication to the indicated address - Automatically every 28 days By Request

Do you agree to generic substitution? Yes No Do you agree to therapeutic substitution? Yes No

I need my first medication on / /20 (Subject to Medical Aid approval)

You must fax us a copy of your valid prescription and send the original by mail within 30 days

The applicant acknowledges that he/she is responsible for payment of any levies, co-payments or rejections that the medical scheme may impose, and to inform Pharmacy Direct of any changes to his/her medical aid detail.
 Only written cancellations of this application will be accepted.

Main Member Signature

Date