[DATE]

Contact Name

Address

Address2

City,

State/Province

Zip/Postal Code

**RE: AUTHORISATION TO PARTICIPATE IN MEDICAL AID PLAN**

To Whom It May Concern:

As an employee of [NAME OF COMPANY], I do [DO/NOT] wish to participate in the Company's Medical Aid Plan.

[NAME OF COMPANY] is hereby authorised to make the necessary deductions from my earnings or any disability benefit paid to me by the company, for the amount specified in the Group Insurance Schedule.

It is my understanding that I will be eligible to participate in the Company Medical Aid Plan as of [DATE] and that the monthly deductions referred to herein will begin on [DATE].

I further understand that the acceptance of my application for participation in the Company Medical Aid Plan is contingent upon my ability to meet the medical requirements determined by [NAME OF INSURANCE COMPANY].

Signature

Employee Name - Print Letters