

CHANGE OF BANKING DETAILS

Please complete all the relevant sections of this form in BLOCK LETTERS.

Fax: 010 597 4708

Email: membership@medshield.co.za

Principal member of medical aid bank details

3rd party bank details authorisation

***Should the bank details provided for debit order details not be that of the principal member of the scheme a bank statement is required.
NB: if bank details are in the name of an Organisation/Company a "Letter of Authority" on company letterhead must accompany this form.**

MEMBERSHIP NUMBER

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

SECTION 1

TO BE COMPLETED BY THE PRINCIPAL MEMBER OF THE SCHEME

PRINCIPAL MEMBER SURNAME

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

PRINCIPAL MEMBER FULL NAME

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

PRINCIPAL MEMBER ID NUMBER

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

I _____ (members full name) the undersigned, declare that the details provided herein is correct

Members signature _____

Date:

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

SECTION 2

TO BE COMPLETED BY ACCOUNT HOLDER

ACCOUNT HOLDER SURNAME

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

ACCOUNT MEMBER FULL NAME

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

ACCOUNT HOLDER ID. NO.

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Use this account for contributions collections and claims refund

Use this account for contribution collections only

Refunds Only

BANK NAME

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

BRANCH NAME

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

BANK BRANCH CODE

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

BANK ACCOUNT NUMBER

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

ACCOUNT HOLDER

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

TYPE OF ACCOUNT

Current	Trasmission	Savings
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I _____ (account holders full name) the undersigned, declare that:

- I understand that Medshield will rely upon the facts set out herein for the accurate loading of bank details. I understand and accept that should and details contained herein prove to be incorrect, or should i fail to inform Medshield of any subsequent change to the bank details, Medshield will not be held responsible.
- I am the account holder of the bank details provided and i hearby authorise Medshield to electronically collect monthly contributions and/or pay refunds to the above bank via the Elektropay system using the information provided. Medshield will not be held responsible.
- I also irrevocably authorise Medshield to reverse any erroneous transaction and/or rectify any electronic transfer of funds error without proir notice.

Date:

D	D	M	M	Y	Y	Y	Y
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Principal Member Signature

Account Holder Signature