



Mark relevant box with an X:

Use this account for:

Contributions only

Contributions and Claim Refunds

Bank Name:

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Branch Name:

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Branch Code:

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Type of Account: (Mark with an X)

Current					Transmission					Savings				
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Bank Account Number:

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Mark relevant box with an X:

Use this account for:

Refunds only

Bank Name:

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Branch Name:

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Branch Code:

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Type of Account: (Mark with an X)

Current					Transmission					Savings				
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Bank Account Number:

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**SECTION C**

**REQUIRED DOCUMENTS**

In order to change your bank details, please provide the below documents for verification purposes:

- Copy of the account holder's ID or copy of passport for non-SA citizens
- Copy of a stamped bank statement (not older than 3 months) or a stamped confirmation letter from the bank in the name of the account holder

Account in the name of an Individual other than the Principal member (for example, spouse, parent, child etc.):

- ID Copy of the Principal Member or copy of passport for non-SA citizens
- ID Copy of the account holder or copy of passport for non-SA citizens
- Copy of a stamped bank statement (not older than 3 months) or a stamped confirmation letter from the bank in the name of the account holder.

Account in the name of a Company:

- Copy of a stamped bank statement (not older than 3 months) or a stamped confirmation letter from the bank in the name of the Company
- Signed letter of authority on a Company letterhead including the details of the member(s)
- ID Copies of each signatory who has authority to sign on behalf of the company
- Copy of Company Registration Certificate

Trust Account:

- Copy of a stamped bank statement (not older than 3 months) or a stamped confirmation letter from the bank in the name of the Trust
- Signed letter of authority including the details of the member(s)
- ID Copies of each trustee
- Copy of Trust Resolution showing the trustees

**SECTION D**

**DECLARATION**

I \_\_\_\_\_ (account holder's 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 any 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 also agree that I am the account holder of the bank details provided and I hereby authorise Medshield to electronically collect monthly contributions and/or pay refunds to the above bank via the Elektropay system using the information provided. I also irrevocably authorise Medshield to reverse any erroneous transaction and/or rectify any electronic transfer of funds error without prior notice.

I hereby authorise Medshield Medical Scheme, or any of its nominated representatives, to verify the bank details as stipulated on this form.

Give consent that Medshield Medical Scheme, may collect, process, store and share our personal information with the Scheme's respective Service Providers including South African Revenue Services. This information includes, but is not limited to details such as, name, surname or registered name (in the cases of companies and trusts), identity numbers, registration number, tax number, addresses and other details which could include financial information and banking details.

Date: 

D	D	M	M	Y	Y	Y	Y
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Principal Member Signature:

Account Holder Signature: