CMAC
Dr. Pikkie Kok
FINANCIAL & HEALTHCARE ADVISOR

MEDSHIELD
medical scheme

CONFIRMATION OF INFORMATION

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

MEMBERSHIP NUMBER

SECTION 1 TO BE COMPLETED BY THE PRINCIPAL MEMBER OF THE SCHEME

MEMBER SURNAME

MEMBER FIRST NAMES

ID NO.

SECTION 2 DEPENDANT DETAILS

DEPENDANT CODE	INITIALS and SURNAME	ID Number

SECTION 3 CONTACT DETAILS

POSTAL ADDRESS

POSTAL CODE

TELEPHONE NO. - -

FAX NO. - -

CELL NO

E-MAIL ADDRESS

SECTION 4 BANK DETAILS OF PRINCIPAL MEMBER

My bank details have changed. I, the undersigned, hereby give Medshield Medical Scheme permission to use the following bank details provided as instructed. I give Medshield the authority to reverse any erroneous transactions and/or rectify any electronic transfer or fund error without prior notice.

***Should the bank details provided for debit order details not be that of the principal member of the Scheme a stamped bank statement is required.**

NB: If bank details are in the name of an Oganisation/Company a "Letter of Authority" on company letterhead must accompany this form.

ACCOUNT HOLDER

BANK NAME

BRANCH

BRANCH CODE

ACCOUNT NUMBER

TYPE OF ACCOUNT CURRENT | TRANSMISSION | SAVINGS

Use this account for:

- ☐ Contribution collections only
- ☐ Contribution collections & claims refunds
- ☐ Claims refunds Only

SIGNATURE OF ACCOUNT HOLDER _____

SECTION 5 MEMBER DECLARATION

I, _____ (account holder's full name) the undersigned, understand that Medshield will rely upon the facts set out herein for the accurate loading of 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 details, Medshield will not be held responsible.

_____ Date: D D M M Y Y Y Y

Principal Member Signature

Completed form must be faxed to 010 597 4708 or submitted via e-mail to membership@medshield.co.za