CMAC
Dr. Pikkie Kok
FINANCIAL & HEALTHCARE ADVISOR

MEDSHIELD
medical scheme

REQUEST FOR CONTRIBUTIONS REFUND

Please complete all the relevant sections of this form in BLOCK LETTERS.
The completed form, together with any relevant documentation, must be faxed to 010 597 4709 or e-mailed to creditcontrol@medshield.co.za

MEMBERSHIP NUMBER

SECTION 1

TO BE COMPLETED BY THE PRINCIPAL MEMBER OF THE SCHEME. ***Compulsory fields**
Please note: Dependant ID numbers are only required if you are an active member of the Scheme. No need to complete the dependant section if you are a terminated member.

* MEMBER SURNAME
* MEMBER FIRST NAMES
* PRINCIPAL MEMBER ID NO.
DEPENDANT ID NO.
DEPENDANT ID NO.
DEPENDANT ID NO.
DEPENDANT ID NO.
DEPENDANT ID NO.
CONTACT NO.

SECTION 2 REFUND DETAILS

Please note: Please enter contributions amount due as it reflects on your last statement received. If no contribution amount reflected on your last statement received please briefly describe your refund request and the period affected.

Last Statement Date
Contributions Balance R
Refund Details Description

SECTION 3 REFUND BANK DETAILS

PLEASE PROVIDE BANKING DETAILS OF THE PERSON THAT THE REFUND IS PAYABLE TO.
Please note: Please provide a copy of your stamped bank statement or cancelled cheque (Name and account holder must be clear on the statement). Refunds for debit order members will be paid into the same account where we received the debit order payment from.

ACCOUNT HOLDER
BANK NAME
BRANCH
ACCOUNT NUMBER
TYPE OF ACCOUNT Current | Transmission | Savings

SECTION 4 MEMBER DECLARATION

I, _____ (Principal Member's full name) the undersigned, upon receiving my signed form, hereby give Medshield Medical Scheme the authority to refund my contributions balance on my request. I acknowledge that:

The details contained herein are true and accurate;
- I am aware that this form must be received by Medshield Medical Scheme before the refund will be authorised.
- I confirm that I will not request a stop payment with my bank for any amounts collected via debit order or via Persal if my contributions are paid via Persal.
- I will be liable for any refund amount refunded to me in error.

_____
Principal Member Signature

DATE D D M M Y Y Y Y

Medshield Medical Scheme
Physical: 288 Kent Avenue, Randburg, 2194 | Postal: PO Box 4346 Randburg 2125 I Contact Centre number 086 000 2120 Web: www.medshield.co.za