

NEW GROUP APPLICATION

Medshield Medical Scheme

P O Box 4346
Randburg
2125

Fax number: 010 597 4710

Email: membership@medshield.co.za

- To be completed by employer if paying contribution/s to the Scheme on behalf of the member/s.
- Please ensure that each participating employee completes a MEM01(A) - Medshield Member Registration form.
- Both pages of the New Group Application must be completed in full.
- Please ensure that the Disclaimer and Payment Terms are read in full.
- Only applicable to groups of 2 or more members.
- Please note that Medshield is registered as an advanced paying Scheme.

SECTION 1

COMPANY DETAILS

REGISTERED NAME OF COMPANY

CONTRIBUTION RAISING ADVANCE ARREARS

EFFECTIVE DATE:

SECTION 2

CONTACT DETAILS

HUMAN RESOURCE CONTACT

TELEPHONE NO. ()

FAX NO. ()

REPRESENTATIVE NAME

REPRESENTATIVE SIGNATURE

E-MAIL ADDRESS

BILLING CONTACT

TELEPHONE NO. () COMPANY STAMP

FAX NO. ()

E-MAIL ADDRESS

COMPANY POSTAL ADDRESS

CODE

COMPANY PHYSICAL ADDRESS

CODE

PREFERRED MEANS OF COMMUNICATION EMAIL FAX POST

SECTION 3

METHOD OF PAYMENT FOR CONTRIBUTIONS

PREFERRED MEANS OF PAYMENT

EFT

ACB

SECTION 4

COMPANY BANK DETAILS

ONLY TO BE COMPLETED IF THE COMPANY BANK ACCOUNT MUST BE DEBITED

I, the undersigned, in my capacity as _____ being authorised by virtue of a resolution of the company dated _____ agree that the below bank account be debited to cover the applicants contributions.

I understand that the contribution may change as a result of future increases or changes to the applicants member records.

BANK NAME												
BRANCH CODE												
BRANCH NAME												
TYPE OF ACCOUNT	Current				Transmission				Savings			
NAME OF ACCOUNT HOLDER												
BANK ACCOUNT NO.												
SIGNATURE OF REPRESENTATIVE												
DATE	D	D	M	M	Y	Y	Y	Y				

IF THE COMPANY BANK ACCOUNT MUST BE DEBITED, A COPY OF A CANCELLED CHEQUE OR BANK STATEMENT FOR VERIFICATION MUST ACCOMPANY THIS APPLICATION.

DISCLAIMER

All contributions are payable monthly and should be paid to the Scheme within three days of the beginning of the due month.

Where contributions or any other debt owing to the Scheme, has not been paid within 30 days of the due date, the Scheme shall have the right:

- To suspend all benefit payments which have accrued to the members of the group during the period of default.
- To give the group written notice that if contributions or such other debts are not paid up to date within 14 days of the receipt of such notice, membership may be cancelled.

No refund of any portion of a contribution shall be paid to any person where such member's membership or cover in respect of any dependant terminates during the course of a month.

In the event of a member ceasing to be a member, any amount still owing by such member is a debt due to the Scheme and recoverable by it.

PAYMENT TERMS

- DEBIT ORDERS This is the official payment method of the scheme.
- ELECTRONIC FUND TRANSFERS It will remain the payees responsibility to provide the group credit controller with a monthly schedule and proof of payment by the 3rd working day of the month.

SECTION 5

CONSULTANT

HEALTHCARE CONSULTANT												
HEALTHCARE CONSULTANT'S NUMBER												
AGENT NUMBER												
TELEPHONE NUMBER												

Date:

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

Signature of Company Representative