

Contact us

Tel: 0800 226 5633 (0800 BANKMED) • Private Bag X2, Rivonia, 2128 • www.bankmed.co.za

Change of Employer Transfer Form

This form may be used to notify Bankmed when an existing Bankmed member changes from one participating employer (e.g. ABSA, FNB, SBSA etc.) to another participating employer and wishes to retain his/her Bankmed membership, without a break in membership or the addition/removal of dependants.

All other information as previously supplied by the member either on his/her application for membership form or in any other engagements with Bankmed, shall remain unchanged, unless Bankmed is notified in writing. Any declarations previously provided by the member remain in force.

Who we are

Bankmed Medical Scheme (referred to as 'the Scheme'), registration number 1279. This is a non-profit organisation, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). Discovery Health is responsible for the administration of Bankmed Medical Scheme.

What you must do

Step 1: Fill in the form

Step 2: Read and understand the information for which you are applying

Step 3: Sign the application

When you sign this application, you confirm that you have read and understood the rules for membership and agree to them. Should you have any questions, kindly let us know. Once we have assessed your application, we will let you know what will happen next.

Section A: (To be completed by the main member)													
Compulsory Information													
Current Bankmed member number:													
RSA Identity or Passport number:													
Preferred e-mail address for Bankmed purposes:													
Preferred cellular number for Bankmed purpo	oses:												
Preferred telephone number for Bankmed pu	rposes:												
Preferred physical or postal address for Bankı	med purposes:												
	Postal code												
Do you wish to exercise a plan change as a result of your change of employment? Yes No													
If yes, please indicate your plan choice in the section below.													
Please note that a change from a savings plan to a non-savings plan may result in a savings claw-back (debt to the Scheme) in the event should the savings utilised in the current benefit year exceeds the savings contributions paid in the current benefit year. Please familiarise yourself with the various Plans before making your choice. Visit www.bankmed.co.za and download the "Benefit and Contribution Schedule".													
Essential Plan	Basic Plan Traditional Plan												
Core Saver Plan	Comprehensive Plan Plus Plan												

Should you select the Core Saver, Comprehensive or Plus Plan, kindly indicate whether or not you want above-tariff portions of claims (amounts charged by doctors that are in excess of the relevant Scheme rate for your plan) to automatically be funded from your available savings. Should you not complete this section, we shall assume that you have selected "No".

Section B: (To be completed by the main member)

Compulsory Information – Confirmation of banking details and debit order authorisation

Kindly complete the sections below to ensure that all banking details and debit order authorisations are current. Please provide banking details for both claims refund and contribution purposes:

		Banking details for claims refund purposes:										Baı	nkin	g de	tails	for	con	ntrib	utio	n (Dek	oit C)rde	r) p	urposes			
Bank (e.g. ABSA, FNB, SBSA, etc.))																											
Branch code (e.g. 632005)																												-
Account number																												
Account type (e.g. Current /Chec	jue,																											
Savings, Transmission)																												
hereby confirm that my em Bankmed, in terms of the Ru and/or debt owing by me in Name And Surnam	les of terms	the	Sche	eme	e. I fi	urtŀ	ner	mor	e a	uth	/ wi oris Sign	e B	ank	med	ion d to	of t	:he hdr	mo aw	nth fro	ly c m r	ny	ban	nk a	ons any M Dat	Y	quir ntril	ed but	by ions
Section C: (For completion	on by	the	nev	w E	mp	loy	er)																					
Compulsory Information (Autho	orised	Com	pany	Sig	nato	ry)																						
Employee name and surname:																								\top		\top		
Applicant's employee number:																												
Date of employment with new o	emplo	yer:	D D)	/1 1\/	1 Y	,	Y	,	Υ	Gro	1 22	mont	thly	sala	iry o	f en	nplo	yee	: [R		_	_	_	_		
Name of employer/company:																												
Employer number:																												
Physical address of employer/co	mpan	ıy:								,																		
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Employer's telephone number:																												
Employer's e-mail address (To b	e used	d by E	Bankr	ned	l whe	en c	orr	espo	ndi	ng v	vith	the	Em	ploy	er):													
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Change of employer transfer for	rm sut	mitte	ed by	ı (in	dicat	te fı	ull r	iame	e an	d su	ırna	me):															_
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Signature Of Personnel Officer/ Designation						tion											Date	ب_										
Payroll Sta										-		,											_					

Please submit completed transfer forms (Signed and stamped by the employer/authorised company signatory)