

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.

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 (referred to as 'the Scheme'), registration number 1279, 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) which takes care of the administration of your membership for the 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.

Section A: (To be completed by the Principal Member)

Compulsory Information

Current Bankmed member number:

RSA Identity or Passport number

Preferred e-mail address for Bankmed purposes:

Preferred cellular number for Bankmed purposes:

Preferred telephone number for Bankmed purposes:

Preferred physical or postal address for Bankmed purposes:

Code

Would you like to change your Plan?

Yes No

If yes, please indicate your Plan choice in the section below.

Please note that a change from a Medical Savings Account Plan to a non-Medical Savings Account Plan may result in a savings claw-back (debt to the Scheme), in the event that the savings utilised in the current benefit year exceeds the Medical Savings Account 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

Section B: (To be completed by the Principal 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	Banking details for contribution (Debit Order) purposes
Bank (e.g Absa, FNB, SBSA, etc.)		
Branch code (e.g 632005)		
Account number		
Account type (e.g. Current/Cheque, Savings, Transmission)		

Debit Order Banking Details:

Physical address of the Accountholder
(Own/Third party/Company/Trust)

		Code	

Please note: This should be provided only if Debit Order Banking details section has been completed above.

I hereby confirm that my employer is authorised to debit my salary with my portion of the monthly contributions required by Bankmed, in terms of the Rules of the Scheme. I furthermore authorise Bankmed to withdraw from my bank any contributions and/or debt owing by me in terms of the Rules of the Scheme.

Principal Member's
Name and Surname

Principal Member's Signature

Date

D	D	M	M	Y	Y	Y	Y
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Section C: (For completion by the new Employer)**Compulsory Information (Authorised Company Signatory)**

Employee name and surname:

Employee number:

Date of employment with new employer:

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Gross monthly salary of employee: R

Name of employer/company:

Employer number:

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Physical address of employer/company:

		Code	

Employer's telephone number:

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Employer's e-mail address (To be used by Bankmed when corresponding with the Employer):

Change of employer transfer form submitted by (indicate full name and surname):

Terms and Conditions

This signed authority and mandate refers to the application on the signed date ("the Agreement")

I/We, the undersigned:

- Warrant that the account information I/we have provided above is an account in my/our name and that the information furnished by me/us in this Authority and Mandate is true and correct.
- Authorise Bankmed Medical Scheme to issue and deliver payment instructions to my bank, recorded above, for the collection by Bankmed Medical Scheme from the bank account (or any other bank or branch to which I may transfer my account) any amounts due under or in terms of this application to change banking details on condition that the sum of such payment instructions will never exceed my obligations as framed in the agreement which shall commence on the date that the banking details are effective and shall continue until this authority and mandate is terminated by me by giving Bankmed Medical Scheme no less than 20 ordinary working days written notice thereof or immediately in the event that I instruct my bank to withdraw this authority and mandate.
- Confirm that that the payment instructions mentioned above must be issued on the first working day of the month. If the change in banking details are not activated in time for the debit order collection and there is an amount outstanding Bankmed Medical Scheme can collect that amount in the interim, upon activation of the banking details. If I change the date of the debit order after activation of the banking details, I confirm that the payment instructions must be issued and delivered on the day that I have nominated ("payment day") and thereafter on the same day in each and every successive month. If the payment day falls on a Sunday or recognised South African public holiday, the payment day will automatically be the next working day.
- Authorise Bankmed Medical Scheme to track my bank account and re-present the payment instruction referred to above in the event that there are insufficient funds in my bank account to meet my obligations under or in terms of this Agreement.
- Acknowledge that my bank will treat each payment instruction to pay premiums or amounts due under this Agreement to Bankmed Medical Scheme as if each payment instruction came from me personally as the account holder.
- Undertake to advise Bankmed Medical Scheme in writing of any changes to my account details and acknowledge that Bankmed Medical Scheme will not be held responsible or liable for any claim, loss or harm that I or any third party may suffer as a result of me providing incorrect banking details herein or if the bank account is in the name of another person or entity or as a result of my failure to notify Bankmed Medical Scheme of a change in banking details or if the bank account has insufficient funds to meet my obligations under or in terms of the Agreement.
- Know and understand that the withdrawals hereby authorised will be processed through a computerised system provided by South African banks. The details of each withdrawal from my bank account will be printed on my bank statement and must show the reference number of the membership inserted in the Agreement so as to enable me to identify this membership.
- Acknowledge that although this Authority and Mandate may be terminated by me, such termination does not necessarily terminate this Agreement. In the event of such termination I am not entitled to any refund of any premiums or amounts due that was withdrawn by Bankmed Medical Scheme whilst this Authority and Mandate was in force if such premiums or amounts were legally owing to Bankmed Medical Scheme in terms of the Agreement.
- Acknowledge that by signing this Authority and Mandate I am bound by the payment terms applicable to this agreement.

Reference number

This Agreement's reference numbers are BANKMEDCON, BANKMEDCLA

Signature of bank account holder

Please only sign if you have read and understand this statement

Date

D	D	M	M	Y	Y	Y	Y
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In addition to the above terms, the policyholder must agree to the following:

1. I confirm that I have the right to give Bankmed Medical Scheme the authority to debit such account on a monthly basis. Furthermore, I will be liable for any claims, losses or damages of whatsoever nature arising out of debits made by Bankmed Medical Scheme to the account as listed above should this account have insufficient funds, be incorrect or be held in the name of any other person.
2. I hereby authorise Bankmed Medical Scheme to verify the banking details as provided above for the purpose of setting up a debit order, in need.
3. I confirm that the account listed above complies with the Financial Intelligence Centre Act ("FICA").
4. I confirm that if I miss a premium collection date I authorise that Bankmed Medical Scheme may deduct a double debit of my premiums the following month.

I, (Full name(s) and surname according to your identity document), as the Principal Member, give Bankmed Medical Scheme permission to change my banking details.

Signed at (town or city) on

D	D	M	M	Y	Y	Y	Y
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Signature of Principal Member

Please only sign if you have read and understand this statement

Signature Of Personnel Officer/
Payroll Stamp

Designation

Date

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