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

Transfer from Active to Retiree Status or Retrenchments

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.

How to complete this form

1. Kindly complete this form and return it to your Human resources department.
2. This form is for Principal Members who:
   a. Move onto retiree status, to be able to make contributions or payments directly to Bankmed. ☐
   b. Have been retrenched but have chosen to maintain their Bankmed membership to be able to make contributions or payments directly to Bankmed. ☐
3. Please use one letter per block, complete with black ink and print clearly.
4. To avoid administration delays, please ensure this application is completed in full.
5. Contact us on 0800 BANKMED (0800 226 5633) for any queries.
6. This form must be sent to **administration@bankmed.co.za** or faxed to **021 527 1926**

1. Member information (Principal Member)

Membership number (compulsory) | Start date D D M M Y Y Y Y

Title | Initials | Surname

First name(s)
(as per identity document)

Preferred name | Sex M F

Date of birth D D M M Y Y Y Y

Marital status ☐ Married ☐ Single ☐ Divorced ☐ Windowed

Date of marriage D D M M Y Y Y Y

Previous/maiden name

ID or passport number

Country of issue

Telephone (H) | (W)

Cellphone | Fax

E-mail address

Postal address

Code

Residential address

Code

2. Banking details for your monthly contributions

What you must do
Submit the following with this form: A copy of your ID and a bank statement/letter of confirmation (not older than three months) from the bank.

These details apply when you pay directly towards your total contribution. Please note that we cannot accept credit card details. You may only use a South African bank account. The first deduction will take place at the beginning of the month following the start date as a retired/retrenched member.

Bank name | Branch name

Account type Cheque ☐ Transmission ☐ Savings ☐ Branch code ☐☐ - ☐☐ - ☐☐

Name of account holder

Account number

Signature of account holder

I, hereby give Bankmed Medical Scheme permission to charge my bank account for my contributions.

3. Banking details for reimbursement of your claims

What you must do
Submit the following with this form: A copy of your ID and a bank statement/letter of confirmation (not older than three months) from the bank.

Same as contribution bank account provided? Yes ☐ No ☐ (if "No", please complete below)

Bank name | Branch name

Account type Cheque ☐ Transmission ☐ Savings ☐ Branch code ☐☐ - ☐☐ - ☐☐

Name of account holder

Account number

Signature of account holder

4. Your legal declaration

It is my sole responsibility as a member to ensure Bankmed Medical Scheme receives the monthly premium. Should contributions be outstanding for two months in a row, my membership will be cancelled in the third month. Short payment or non-payment of any of my contributions will result in suspension of my claims.

I confirm the content of this application is true and complete.

I agree to advise Bankmed Medical Scheme in writing of any change in details that may occur between the date of this application form and the activation of my membership with Bankmed Medical Scheme.

Signed at on D D M M Y Y Y Y

Signature of Principal Member

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5. Your employment details

Kindly note this section should not be completed by SBSA Employees.
Should your employer be paying your full contribution or a part thereof, please complete this section:

Name of employer | Employer of billing number

Employee number | Date of employment (Y Y Y Y M M D D)

1. Employee contact person

Telephone

E-mail

2. Employee contact person

Telephone

E-mail

Branch name | Branch number

Department name | Department number

Kindly ensure your employer completes this warranty.

Employer warranty

1. We warrant that the main applicant detailed in section 1 is an employee of our organisation
2. The Scheme may bill us for the amount due for this member in the same way as it does for our other employees with the Scheme.

Authorised signatory 1. | Authorised signatory 2.

Name/s | Name/s

Designation | Designation