Contact details
Tel: 0860 101 252 • PO Box 652509, Benmore 2010 • www.retailmedicalscheme.co.za

Request to change banking details

This is a form to change banking details

Who we are

Retail Medical Scheme registration number 1176, referred to as “the Scheme” 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 (Pty) Ltd administers Retail Medical Scheme.

How to complete this form

- Please use one letter per block, complete in black ink and print clearly.
- To avoid administration delays, please ensure this application is completed in full.
- Please email the completed form to **bankingdetails@retailmedicalscheme.co.za**.
- Alternatively, you can update your bank details by visiting **www.retailmedicalscheme.co.za**.

You need to submit the following with this form:
Supporting documents required

Please send the completed Request to change bank details form back to us with the documents required under each type of bank account. Please only send the documents relevant to your update. These documents are only applicable or needed when you are using one of the bank account types listed below.

When using another person’s bank account (for example that of your spouse, aunt, uncle, friend, father, son):

- Proof of the account, like a copy of the bank statement, not older than three months;
- A copy of the ID, passport or driver's licence of the bank account owner.

When using a joint account:

- Proof of the account, like a copy of the bank statement or letter from the bank on a bank letterhead (the proof must not be older than three months from the day that you send it to us);
- A copy of the ID, passport or driver's licence of each of the joint owners.

When using a company account:

- Proof of the account, like a copy of the bank statement or letter from the bank on a bank letterhead (the proof of account must not be older than three months from the day that you send it to us);
- A copy of the ID, passport or driver's licence of each signatory or person who has authority to sign on behalf of the company;
- A letter of authority including the details of all the persons of authority and membership details;
- A copy of the company’s certificate of registration.

When using a trust account:

- Proof of the account, like a copy of the bank statement or letter from the bank on a bank letterhead (the proof must not be older than three months from the day that you send it to us);
- A copy of the ID, passport or driver's licence of each of the trustees of the account;
- A copy of the trust’s certificate of registration;
- A copy of the trust resolution, showing the trustees.

If the account is in your name, and you are the main member, but we are unable to verify the account details with the bank, we will need the following documents:

- Proof of the account, like a copy of the bank statement or letter from the bank on a bank letterhead (the proof must not be older than three months from the day that you send it to us);
- A copy of your ID, passport or driver's licence.

1. What would you like to change?

Debit order details ☐ Claim payment details ☐ Both ☐

2. Main member's details

Membership number

ID or passport number

Member's name

Member's surname

3. Previous bank account details

Account holder

Bank

Account number

Branch number - -

Branch name

Type of account Cheque ☐ Savings ☐

4. New bank account details for debit orders

We will start using these banking details once they are loaded onto the system.

Please note we cannot accept credit card details

Account owner (Mark with an x) You ☐ Someone else ☐ Company ☐ Trust ☐

Bank name

Branch name

Branch code - -

Account number

Type of account Cheque ☐ Savings ☐

Account holder

Signature of bank account holder

Date D D M M Y Y Y Y

I confirm that the account listed above complies with the Financial Intelligence Centre Act ("FICA").

Account holder residential address (If the account holder is a company, please state the company address)

Address line 1

Address line 2

City

Suburb

Postal code

Account holder email address (If the account holder is a company, please state the company email address)

Account holder contact number (If the account holder is a company, please state the company contact number)

Due to the Payment Association of South Africa (PASA) debit order mandate requirements, you are required to supply the account holder's residential address, email address and contact number. Please note that the details you supply will only be used for the PASA debit order mandate requirement, and will not be used to update the contact details we have on system. If you wish to update any contact details please visit **www.retailmedicalscheme.co.za**.

If an account held in another person's name (third-party) is being used, for example, that of your spouse, friend or daughter, company (authorised person) or trust (trustee), please complete the details below.

Title Initials

Surname

First name(s)
(as per identity book)

Preferred name

Gender M F Date of birth D D M M Y Y Y Y

ID or passport number

Please also complete the details below for **company** or **trust** accounts.

Company or trust

Registration number

Signature of authorised party / trustee

Date D D M M Y Y Y Y

If there are multiple authorised parties / trustees, please attach ID copies per authorised party / trustee.

Your banking details will only be changed if:

1. All the current membership details you supply on this form correspond with the existing information stored by Retail Medical Scheme
2. The request to change banking details has been signed by the main member
3. Documentation required under "How to complete this form" accompanies this form.

5. New bank account details for claims payment

We will start using these banking details once they are loaded onto the system.

Please note we cannot accept credit card details

Account owner (Mark with an x) You Someone else Company Trust

Bank name

Branch code - -

Account number

Type of account Cheque Savings

Account holder

Signature of bank account holder

Date D D M M Y Y Y Y

I confirm that the account listed above complies with the Financial Intelligence Centre Act ("FICA").

If an account held in another person's name (third-party) is being used, for example, that of your spouse, friend or daughter, company (authorised person) or trust (trustee), please complete the details below.

Title Initials Surname

First name(s) (as per identity book)

Gender M F Date of birth D D M M Y Y Y Y

ID or passport number

Please also complete the details below for **company** or **trust** accounts.

Company or trust

Registration number

Signature of authorised party / trustee

Date D D M M Y Y Y Y

If there are multiple authorised parties / trustees, please attach ID copies per authorised party / trustee.

Your banking details will only be changed if:

1. All the current membership details you supply on this form correspond with the existing information stored by Retail Medical Scheme
2. The request to change banking details has been signed by the main member
3. Documentation required under "How to complete this form" accompanies this form.

I, (first and last name), as the main member, give the Scheme permission to change my banking details.

Signed at (town or city)

Signature of main member

Date D D M M Y Y Y Y

Please do not sign an incomplete application form.

6. Debit Order Mandate

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 Retail Medical Scheme to issue and deliver payment instructions to my bank, recorded above, for the collection by the 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 Retail Medical Scheme no less than 20 ordinary working days written notice thereof, or immediately when I instruct my bank to withdraw this authority and mandate.
- Confirm 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, Retail 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 Retail 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. I confirm that if I miss a premium collection date I authorise that Retail Medical Scheme may deduct a double debit of my premiums the following month.
- Acknowledge that my bank will treat each payment instruction to pay contributions or amounts due under this agreement to the Scheme as if each payment instruction came from me personally as the account holder.
- Undertake to advise Retail Medical Scheme in writing of any changes to my account details and acknowledge that Retail 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 the 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 I may terminate this authority and mandate, such termination does not necessarily terminate this agreement. In the event of such termination I am not entitled to any refund of any contributions or amounts due that was withdrawn by Retail Medical Scheme whilst this authority and mandate was in force if such contributions or amounts were legally owing to Retail 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.

In addition to the above terms, I, as the main member:

1. Confirm that I have the right to give Retail 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 Retail 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. Hereby authorise Retail Medical Scheme to verify the banking details as provided above for the purposes of setting up the debit order, in need.

Privacy Statement

We process your personal information in accordance with the provisions of the Scheme's Privacy Statement. Please read the Privacy Statement by going to www.retailmedicalscheme.co.za. By accepting these Terms and Conditions and/or by providing personal information to us you agree and give consent to the provisions of our privacy statement.

If you do not agree or give consent to us using your personal information, we may not be able maintain your membership of the Scheme. If you believe we have acted contrary to these provisions, please let our privacy office know by contacting us on **www.retailmedicalscheme.co.za**

Reference number
This Agreement reference number: Your membership number

Abbreviated name
Abbreviated Name as Registered with the Bank: RETAILCONT/RETAILCLAW

Deduction amount: as per your activation of membership letter
Deduction date: as per section 1 of your membership application form
Payment start date: as per section 1 of your membership application form

Signature of bank account holder

Date D D M M Y Y Y Y