

6. YOUR BANKING DETAILS

DEBIT ORDER FOR MONTHLY CONTRIBUTIONS BANKING DETAILS

For monthly contributions, please complete your debit order deduction banking details below

* Debit order deduction date	20 th	25 th	1 st
Bank			
Branch			
Branch code		Type of account	Cheque/current Savings
Account number			
Select account holder	Member	Company*	Other*

*If you have selected "COMPANY" or "OTHER" please complete the sections below, including the address section. This is in accordance with SARS legislative requirements.

COMPANY

Registered name of company	
Type of company (e.g. private)	
Entity registration number	

OTHER

Title											
First name											
Middle name											
Surname											
Account holder ID number											
Passport number (for non-SA citizens)											
Country of issue											
SARS tax number (mandatory)		Date of birth	D	D	M	M	Y	Y	Y	Y	
Physical address <small>(mandatory field for both "COMPANY" and "OTHER")</small>										Postal code	
Is your physical address the same as your postal address?	Yes	No									
Postal address <small>(Domicilium citandi et executandi)</small>										Postal code	

CLAIMS REFUND BANKING DETAILS

Is your claims refund banking details the same as your monthly contributions banking details?

Yes No

If you selected "NO", please complete your claims refund banking details below

Bank			
Branch			
Branch code		Type of account	Cheque/current Savings
Account number			
Name of the account holder			
If account holder differs from principal member, please confirm account holder ID number/passport number for non-SA citizens			
Account holder ID number			

I/we hereby authorise Bestmed to draw against my/our account with the above-mentioned bank (or any other bank or branch to which I/we may transfer my/our account), the contribution amount for the selected benefit option on the above mentioned date or the first working day thereafter. I/we further authorise Bestmed to adjust the amount due as contributions are amended from time to time. All such withdrawals from my/our account by Bestmed shall be treated as though they have been signed by me/us personally. I/we agree to pay bank charges relating to this debit order instruction. This authority may be cancelled by me/us by giving Bestmed one month's notice in writing via email, fax or registered post, starting on the first day of the following calendar month. Should there be a breach of this contract there is a possibility that the member will be held responsible for payments incurred. I/we understand that I/we shall not be entitled to any refunds of amounts which have been withdrawn while this authority was in force if such amounts were legally owing to Bestmed. I/we acknowledge that the party hereby authorised to effect the drawing(s) against my/our account may not cede or assign any of its rights to any third party without my/our prior written consent and that I/we may not delegate any of my/our obligations in terms of this contract/authority to any third party without prior written consent of the authorised party. The deduction of debit order will take place in the month before inception date should you choose the 20th or 25th as the debit order date subject to subscriptions payable in advance.

Signature of principal member

Signature of account holder

7. DEPENDANTS TO BE ADDED

1. Dependant details

First name

Surname

ID number (passport number for non-SA citizens) Gender M F

Country of issue Date of birth

SARS tax number

Dependant contact number

Email address

The provision of contact information for your dependant/s 18 years and older will allow Bestmed to communicate personal information related to the applicable dependant/s directly to them, in line with the POPI Act.

Relationship to principal member (Indicate with an 'X')

Spouse/common-law spouse Partner/fiancé (complete declaration in section 8) Child (if difference in surname, complete declaration in section 9) Other

If other, please specify relationship:
(affidavit/legal documents) _____

2. Dependant details

First name

Surname

ID number (passport number for non-SA citizens) Gender M F

Country of issue Date of birth

SARS tax number

Dependant contact number

Email address

The provision of contact information for your dependant/s 18 years and older will allow Bestmed to communicate personal information related to the applicable dependant/s directly to them, in line with the POPI Act.

Relationship to principal member (Indicate with an 'X')

Spouse/common-law spouse Partner/fiancé (complete declaration in section 8) Child (if difference in surname, complete declaration in section 9) Other

If other, please specify relationship:
(affidavit/legal documents) _____

