

**FORM TO CHANGE BANKING DETAILS**

**What you must do**

Please go through these two steps:

- Step 1: Fill in the form from **step 1-5**.
- Step 2: Sign the application at **step 6 and 7**.

**How to complete this form**

- To avoid administration delays, please make sure this form is completed in full.
- Once completed, please e-mail your form to [membership@bestmed.co.za](mailto:membership@bestmed.co.za)

**Your banking details will only be changed if:**

1. The information on this form matches the information on Bestmed's records at the moment.
2. This form has been signed by the principal member as well as the account holder, if different.

**NOTE : PLEASE ATTACH THE FOLLOWING**

*NOTE: Proof of bank account not older than 3 months must be attached hereto for verification purposes*

**1. BANK DETAILS TO BE CHANGED**

Contributions	Claims	All
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**2. PRINCIPAL MEMBER'S DETAILS**

Membership number

ID number

Cellphone number  Telephone number

E-mail

I,

(Name & surname) as principal member give Bestmed permission to change my banking details.

**3. PREVIOUS ACCOUNT DETAILS**

Account holder

Bank

Branch name  Branch code

Account number

Type of account

## 4. NEW ACCOUNT DETAILS

Effective date for change	D	D	M	M	Y	Y	Y	Y	* Debit order deduction date	20 <sup>th</sup>	25 <sup>th</sup>	1 <sup>st</sup>
Account holder name												
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?

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

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												



3. In as far as I provide Bestmed with the Personal Information of any third party, including my spouse(s), children or other dependants, I hereby warrant that I have acquired the consent of such third party to do so and in the event of that individual being a child, I do so in my capacity as a "competent person" in respect of such Personal Information, as contemplated in terms of the provisions of POPIA.

Accordingly, I hereby indemnify and hold Bestmed harmless against any claims of whatever nature that may arise as a result of the processing of any Personal Information as provided by myself, for purposes of my membership with Bestmed.

4. Bestmed may identify other products and services which might be of interest to me, as well as to inform me of such products and/or services.

Yes	No
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Signature of principal member