



# BANKING DETAILS

PLEASE COMPLETE FORM IN BLOCK LETTERS

## 1. PRINCIPAL MEMBER'S DETAILS

Membership number	<input type="text"/>		
Title	<input type="text"/>	Initials	<input type="text"/>
ID/Passport number	<input type="text"/>	Contact number	<input type="text"/>
Full name and surname	<input type="text"/>		
Email address	<input type="text"/>		

## 2. BANK ACCOUNT HOLDER'S DETAILS

Name of account holder	<input type="text"/>		
Account number	<input type="text"/>		
Bank name	<input type="text"/>		
Branch name	<input type="text"/>		
Branch code	<input type="text"/>	Account type	<input type="text"/>

- Please use these banking details to debit my monthly contributions.
- Please use these banking details to pay any refunds due to me.

### PLEASE NOTE:

- Please do not provide credit card details as credit card transactions are not allowed for medical scheme contributions and refunds.
- Any changes to your banking details will only be processed upon receipt of a valid copy of your identity document (ID) and proof of bank account details in the form of confirmation letter or a stamped bank statement.
- You will receive your billing statement and details as usual and the debit order will be actioned at least 10 days after the date of the statement.
- If you do not want a debit order to be actioned, kindly contact us on **0860 005 037** so that alternate arrangements can be made.

Signature of account holder	<input type="text"/>	Date	<input type="text" value="DD/MM/YYYY"/>
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## 3. MEMBER DECLARATION

- I hereby instruct and authorise PG Group Medical Scheme to debit any amounts which may be due by me to the Scheme from the abovementioned bank account.
- I hereby instruct and authorise PG Group Medical Scheme to credit any amounts which may be due to me from the Scheme to the abovementioned bank account.
- I understand that the debit/credit transfers hereby authorised will be processed electronically and that details of each transaction will reflect on my medical claims statement.

### 3. MEMBER DECLARATION (CONTINUED)

- I agree to pay any bank charges relating to a debit order instruction.
- I understand that the Scheme will provide me with billing statements and that any authorised debit/credit will be actioned at least 10 days after the date of the statement.
- I understand that this authority may be cancelled by me by giving 30 days' written notice to the Scheme.
- I understand that I shall not be entitled to any refund amounts, which may have been withdrawn while this authority was in force if such amounts were legally owing by me.

I, the undersigned, declare that I have carefully read this application form, completed it in full, and confirm that all the information provided herein to be true and correct to the best of my knowledge.

Signature of principal member	<input type="text"/>	Date	<input type="text" value="DD/MM/YYYY"/>
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**DISCLAIMER:**

PG Group Medical Scheme reserves the right to list members who, in the opinion of the Scheme's Administrator, Momentum Health Solutions (Pty) Ltd Fraud and Ethics Committee, have behaved unethically towards the Scheme, abused their benefits, perpetrated fraud or colluded with others to perpetrate fraud against the Scheme, on the TransUnion Credit Bureau. This information may be viewed by all medical schemes that participate in the Board of Healthcare Funders' (BHF) Forensic Management Unit.



02/2023

Administered by Momentum Health Solutions (Pty) Ltd

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