ANGLOVAAL GROUP MEDICAL SCHEME

Administered by Discovery Health

**Contact details**
Tel: 0860 100 693 • PO Box 652509, Benmore 2010 • www.avgms.co.za

# Request to change banking details

**This is a form to change banking details**

**Who we are**
The Anglovaal Group Medical Scheme (referred to as 'the Scheme'), registration number 1571. This 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). We take care of the administration of your membership for the Scheme.

**How to complete this form**

1. Please use one letter per block, complete in black ink and print clearly.
2. To avoid administration delays, please ensure this application is completed in full.
3. You need to submit the following with this form:

Please send the completed *Request to change bank details* form back to us with the documents 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, 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 drivers 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 drivers 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 drivers 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 the policy or 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 drivers 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 trustee

If the **account is in your name** as the policyholder or 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 drivers licence.

4. Please email this completed and signed form with any supporting documentation to bankingdetails@avgms.co.za
5. When you sign this application, you confirm that you have read and understood the rules for membership and agree to them
6. Alternatively, you can update your bank details by visiting **www.avgms.co.za** if you are a registered web-user.

## 1. What would you like to change?

Debit order details ☐ Claim payment details ☐ Both ☐

## 2. Main member details

Membership number

ID or passport number

Member's name

Member's surname

## 3. New account details for Debit Orders

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

**Please not 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 account holder Date D D M M Y Y Y Y

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

Address line 1

Address line 2

Suburb

City

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)

As part of 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.avgms.co.za**

If an account held in another person's name (third-party) is being used, for example, 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

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Do not want to disclose ☐

*This information is required by the Council for Medical Scheme for statistical purposes. You are not compelled to provide this information.*

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 relevant fields on this request form have been filled in
2. The request has been signed by the principal member
3. Documentation required in step three of “How to complete this form” accompanies this form

I, (first and last name), as the principal 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

If the account holder differs from the main member, the Scheme and the administrator reserve the right to obtain bank confirmation.

## 4. New account details for claims payment

When should we start using the new banking details? D D M M Y Y Y Y

As per debit details ☐

**Please note that we cannot accept credit card details.**

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

Only select someone else’s name if the payments must be made into another person’s bank account (for example, an account belonging to your spouse, grandfather, mother, friend, cousin, authorised party (company) or trustee)

Bank name

Branch name

Branch code

Account number

Type of account Cheque ☐ Savings ☐

Account holder

Signature of account holder

Date D D M M Y Y Y Y

If an account held in another person’s name (third-party) is being used, for example, 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

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Do not want to disclose ☐

*You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.*

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 relevant fields on this request form have been filled in.
2. The request has been signed by the main member.
3. Documentation required in step three of “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)(town or city)(town or city)(town or city)

on D D M M Y Y Y Y

Signature of main member

**Please do not sign an incomplete application form.**

If the account holder differs from the main member, the Scheme and the administrator reserve the right to obtain bank confirmation.

## 5. Debit order mandate

This signed authority and mandate refers to the application on the signed date (‘’the Agreement’’)

I, the undersigned:

- Warrant that the account information I have provided above is an account in my name and that the information furnished by me/us in this Authority and Mandate is true and correct;
- Authorise Anglovaal Group Medical Scheme to issue and deliver payment instructions to my bank, recorded above, for the collection by Anglovaal Group Medical 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 on condition that the sum of such payment instructions will never exceed my obligations as framed in the which shall commence on the date that cover starts as requested on the application form and shall continue until this Authority and Mandate is terminated by me by giving Anglovaal Group Medical Scheme no less than 20 ordinary working days written notice thereof or immediately in the event that 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 membership is not activated in time for the debit order collection and there is an amount outstanding Anglovaal Group Medical Scheme can collect that amount in the interim, upon activation. If I change the date of the debit order after activation, 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 Anglovaal Group 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.
- Acknowledge that my bank will treat each payment instruction to pay premiums or amounts due under this Agreement to Anglovaal Group Medical Scheme as if each payment instruction came from me personally as the account holder.
- Undertake to advise Anglovaal Group Medical Scheme in writing of any changes to my account details and acknowledge that Anglovaal Group 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 Anglovaal Group Medical 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 authorized will be processed through a computerized 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 this Authority and Mandate may be terminated by me, such termination does not necessarily terminate this Agreement . In the event of such termination I am not entitled to any refund of any premiums or amounts due that was withdrawn by Anglovaal Group Medical Scheme whilst this Authority and Mandate was in force if such premiums or amounts were legally owing to Anglovaal Group Medical Scheme in terms of the Agreement;

**Privacy Statement**

We process your personal information in accordance with the provisions of our Privacy Statement. Please read our Privacy Statement by going to www.avgms.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 to provide our products or services to you. If you believe we have acted contrary to these provisions, please let our privacy office know by contacting us on www.avgms.co.za.

**Reference number**

This Agreement reference number: System generated reference number

**Abbreviated name**

Abbreviated name as Registered with the Bank: ANGLO CONT, ANGLOCLAWB

Deduction date: as per signed contract

Deduction amount: as per signed contract

Payment start date: as per signed contract

Signature of bank account holder

Date D D M M Y Y Y Y

**Please only sign if you have read and understand this statement**

**In addition to the above terms, the policyholder must agree to the following**

1. I confirm that I have the right to give Angovaal Group 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 Angovaal Group 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. I hereby authorise Angovaal Group Medical Scheme to verify the banking details as provided above for the purposes of setting up the debit order, in need.
3. I confirm that the account listed above complies with the Financial Intelligence Centre Act (“FICA”).
4. I confirm that if I miss a premium collection date I authorise that Angovaal Group Medical Scheme may deduct a double debit of my premiums the following month.

I,

(full name (s) and surname, according to your identity document. As the main member, give Angovaal Group Medical Scheme acting in their relevant capacities permission to change my banking details.

Signed at (town or city)

on D D M M Y Y Y Y

Signature of main member

**Please only sign if you have read and understand this statement**