MEDSHIELD medical scheme

NEW EMPLOYER GROUP APPLICATION

Email: newapplication@medshield.co.za

This document is an application form for an Employer Group.

Please complete in black ink. All sections to be completed in full. Print clearly using capital letters. Only one character per block. Leave one block between words. Tick the relevant selection.

All relevant sections must be signed.

Each employee joining Medshield Medical Scheme must complete a separate Medshield Member Registration form.

SECTION A — COMPANY DETAILS

Registered Name of Company:

Billing Method: (Mark with an tick) Advance / Arrears

Start Date: D D M M Y Y Y Y

Company Postal Address:

Company Postal Code:

Company Physical Address:

Company Postal Code:

SECTION B — CONTACT PERSON (Authorised representative responsible for contributions and member amendments)

Name:

Surname:

Designation:

Telephone Number:

Email Address:

SECTION C — MEMBERSHIP CARD DELIVERY

Membership Card Delivery: (Mark with an tick) Broker/Consultant / Employer Group / Member

SECTION D — COMPANY PAYMENT DETAILS

Method of Payment: (Tick the relevant selection) EFT / ACB

Medshield is an Authorised Financial Services Provider (FSP 51381)

ONLY TO BE COMPLETED IF THE PAYMENT METHOD IS VIA DEBIT ORDER (ACB):

I, the undersigned, in my capacity as ______________________________ being authorised by virtue of a resolution of the company dated ______________________________ agree that the below bank account be debited to cover the applicants contributions.

I understand that the contribution may change as a result of future increases or changes to the applicants member records.

Bank Name:	
Branch Name:	
Branch Code:	
Type of Account: (Mark with an tick)	Current / Transmission / Savings
Name of Account Holder:	
Bank Account Number:	
Name of Authorised Representative:	
Date:	D D M M Y Y Y Y

Signature of Authorised Representative: ______________________________

A COMPANY BANK STATEMENT OR STAMPED BANK CONFIRMATION LETTER FROM THE BANK MUST ACCOMPANY THIS APPLICATION FORM.

SECTION E — TERMS AND CONDITIONS

- We agree that the Rules of Medshield Medical Scheme, as amended from time to time, shall be binding on us.
- We agree that the monthly contributions shall be paid by no later than the 3rd working day of the month.
- We agree to inform the Scheme immediately of any changes and employee resignations and understand that the Scheme will not backdate any amendments.
- In the event of a member ceasing to be a member, any amount still owing by such member is a debt due to the Scheme and recoverable by it.
- We confirm that the authorised Company Representative have the relevant consent from the Medshield member/s to share information and request changes relating to their membership with the Scheme. This will be limited to information that is relevant to their application, collection of contributions and information that is required for the ongoing servicing of their membership, but will not include any health information unless the specific member have given Medshield permission to do so.
- We provide consent that all conversations between the authorised Company Representative and the Scheme or its contracted service providers, may be recorded.

COMPANY STAMP

Tick this box if no Company Stamp is available

By selecting this box you confirm that the Employer has granted approval

Signature of Authorised Company Representative: ______________________________ Date: D D M M Y Y Y Y

SECTION F — BROKER CONSULTANT

Brokerage Name:	Atfin Consulting (Pty) Ltd
Broker Code:	62370894