Permission to change banking details

This is a form to change banking details

Contact details
Tel: 0860 002 133 • PO Box 10436, Johannesburg, 2000 • www.sabmas.co.za

Who we are

SAB Medical Aid (referred to as 'the Scheme'), registration number 1209, is a not-for-profit organisation, registered with the Council for Medical Schemes.

3Sixty Health (Pty) Ltd, registration number 1978/001109/07, is an accredited administration and managed care service provider responsible for administration of your membership on behalf of the Scheme.

How to complete this form

1. Please use one letter for each block, complete with black ink and print clearly.
2. To avoid administration delays, please make sure this form is completed in full.
3. Once the form is complete, please email it to banking@sabmas.co.za
4. Supporting documents required:

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:

Third party

- Proof of the bank account or letter from the bank on a bank letterhead not older than 3 months
- Copy of the bank statement not older than 3 months
- Copy of ID or Passport or Drivers licence of the account holder

Company account

- Proof of the bank account or letter from the bank on a bank letterhead not older than 3 months
- Copy of ID or Passport or Drivers licence of each signatory
- Letter of authority including the details of all the persons of authority and the policy or membership details
- Copy of the company's certificate of registration
- Copy of the trust resolution, showing the trustees

Trust account

- Proof of the bank account or letter from the bank on a bank letterhead not older than 3 months
- Copy of ID or Passport or Drivers licence of each trustee
- Copy of the trust's certificate of registration
- Copy of the trust resolution, showing the trustees

Account holder

- Proof of the bank account or letter from the bank on a bank letterhead not older than 3 months
- Copy of ID or Passport or Drivers licence

When you sign this application, you confirm that the information provided is true and correct.

Alternatively, you can update your bank details by visiting **www.sabmas.co.za** if you are registered on the SABMAS website.

1. What would you like to change?

Debit order details ☐ Claim payment details ☐ Both ☐

2. Main member's details

Membership number

ID/passport number

Member's surname

Member's name

3. New bank account details for debit orders

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

Please note that 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 bank 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

City

Suburb

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)

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 Male Female Date of birth D D - M M - Y Y Y Y

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 for each authorised party / trustee.

4. New bank account details for claim payments

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

As per debit order details?

Please note that we cannot accept credit card details.

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 (trust).

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 bank 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

City

Suburb

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)

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 Male ☐ Female ☐ | Date of birth D D - M M - Y Y Y Y

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 for each 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 5 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)

Signature of main member

Date D D M M Y Y Y Y

Please do not sign an incomplete application form.

If the account holder is not the main member, the Scheme and the administrator reserve the right to obtain bank information.

5. Terms and Conditions

This signed authority and mandate refers to the application on the signed date (''the agreement'')

I/We, the undersigned:
warrant that the account information I/we have provided above is an account in my/our name and that the information furnished by me/us in this authority and mandate is true and correct;

- authorise SAB Medical Aid to issue and deliver payment instructions to my bank, recorded above, for the collection by SAB Medical Aid 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 to change banking details on condition that the sum of such payment instructions will never exceed my obligations as framed in the agreement which shall commence on the date that the banking details are effective and shall continue until this authority and mandate is terminated by me by giving SAB Medical Aid no less than 20 ordinary working days written notice thereof or immediately in the event that I instruct my bankto withdraw this authority and mandate.
- confirm that that the payment instructions mentioned above must be issued on the first working day of the month. If the change in banking details are not activated in time for the debit order collection and there is an amount outstanding SAB Medical Aid can collect that amount in the interim, upon activation of the banking details. If I change the date of the debit order after activation of the banking details, 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 SAB Medical Aid 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 SAB Medical Aid as if each payment instruction came from me personally as the account holder.
- undertake to advise SAB Medical Aid in writing of any changes to my account details and acknowledge that SAB Medical Aid 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 SAB Medical Aid 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 authorised will be processed through a computerised 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 SAB Medical Aid whilst this authority and mandate was in force if such premiums or amounts were legally owing to SAB Medical Aid in terms of the agreement;
- acknowledge that by signing this authority and mandate I am bound by the payment terms applicable to this agreement.

Reference number

This Agreement reference numbers are SAB CONTRI, SABCLAWBAC

Signature of bank account holder

Date D D M M Y Y Y Y

Please only sign if you have read and understood 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 SAB Medical Aid 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 SAB Medical Aid 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. hereby authorize SAB Medical Aid to verify the banking details as provided above for the purpose of setting up a 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 authorize that SAB Medical Aid may deduct a double debit of my premiums the following month.

I, _____ (Full name(s) and surname according to your identity document), as the policy holder, give SAB Medical Aid and its subsidiaries in their relevant capacities permission to change my banking details.

Date D D M M Y Y Y Y

Signature of main member

Date D D M M Y Y Y Y

Please only sign if you have read and understood this statement