

Employer Information Form for Flexicare 2024

Contact us

Tel: 0860 444 779; 1 Discovery Place, Sandton, 2196; PO Box 784262, Sandton, 2146; www.discovery.co.za

Who we are

Flexicare is not a medical scheme. The cover is not the same as that of a medical scheme and is not intended to be a substitute for medical scheme membership. Flexicare is administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07 an authorised financial services provider and underwritten by Auto & General Insurance Company Limited, registration number 1973/016880/06, an authorised insurer and financial services provider. Terms, conditions and limits apply.

What you must do

- Fill in the form in black ink and print clearly or complete the form digitally.
- This form ("the Information Form") must be completed and returned to Flexicare together with the signed Flexicare employer contract for registration of the Product. The signed quotation, this Information form and the employer contract together will constitute your agreement with Flexicare for the Product.
- Sign section 6. This section must be physically signed and may not be signed digitally.
- Email the signed employer contract and this Information form to **GroupApplication@discovery.co.za**

1. About your organisation

When do you want your cover to start?

D	D	M	M	Y	Y	Y	Y
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Name of employer

Registration number Employer number

VAT number Branch number

Legal entity, for example (Pty) Ltd,

Physical address

Suite number Complex name

Street number Street name

Suburb Postal code

Postal address (Post collected from post box, suite or private bag)

If you do not complete a postal address, we will use your physical address for the post.

☐ PO Box ☐ Private Bag Box number

☐ Suite ☐ Postnet Suite Number

Suburb Postal code

In what industry do you operate? Please tick the applicable block.

☐ Mining and mining resources ☐ Financial Services ☐ Retail ☐ Construction/building ☐ Manufacturing

☐ Hotel/leisure/entertainment ☐ Professional services ☐ Education ☐ Religious organisations ☐ IT

Other (please specify)

COID (workman's compensation) registration number

2. Your organisation's contact person

2.1. Contact person (This is the Employer contact person who is authorised to deal with us and send us financial and other changes for your Employees)

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s) (as per identity document)	<input type="text"/>		
ID or passport number	<input type="text"/>	Employee number	<input type="text"/>
Telephone (H)	<input type="text"/>	Telephone (W)	<input type="text"/>
Cellphone	<input type="text"/>	Fax	<input type="text"/>
Email address	<input type="text"/>		

3. Banking details for your monthly contributions (if applicable)

You may only provide a South African bank account. Payment of all fees will be in advance and by means of a debit order, unless you have an existing payment arrangement with Discovery Health, in which case that payment arrangement will also be applied to the fees payable in terms of this product. If the product is not activated prior to the debit order submission, the initial fee will be included in the following month's debit order.

Please note: We do not accept credit card details and you can only use a South African bank account.

Bank name	<input type="text"/>		
Branch name	<input type="text"/>	Branch code	<input type="text"/>
Account number	<input type="text"/>	Type of account	Cheque <input type="checkbox"/> Savings <input type="checkbox"/>
Name of account holder	<input type="text"/>		
Authorised signatory (ies) on behalf of the employer and employees duly authorised:			
Name(s)	<input type="text"/>	Name(s)	<input type="text"/>
Designation(s)	<input type="text"/>	Designation(s)	<input type="text"/>

4. Flexicare Debit Order Mandate

Note: If the request to change bank details is submitted within five days from the next debit order date, the debit order might still be submitted on the old bank account as we need a minimum of five days' notice to update bank details.

Supporting documents required

Please send the signed Request To Change Bank Details Online Mandate 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 contact persons 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 license of the employer and 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 license of each of the joint account 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 must not be older than three months from the day that you send it to us)
- A copy of the ID, passport or drivers license 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 license 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 trustees

If you have staff members on one of the medical schemes administered by Discovery Health, we will align the billing method to the scheme's. If you are currently a cash payer, you can choose to pay for Flexicare through a debit order, where your premiums will be deducted through a debit order, please complete the below details:

Name of accountholder																								
Address																								
Bank																								
Branch and code																								
Account number																								
Type of account																								
Amount	R															Date	D	D	M	M	Y	Y	Y	Y
To: (name of beneficiary)																								

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 Flexicare to issue and deliver payment instructions to my bank, recorded above, for the collection by Flexicare 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 Flexicare no less than 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 change in banking details are not activated in time for the debit order collection and there is an amount outstanding, Flexicare 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 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 Flexicare 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 Flexicare as if each payment instruction came from me personally as the account holder.
- Undertake to advise Flexicare in writing of any changes to my account details and acknowledge that Flexicare 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 Flexicare 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 In the event of such termination, I am not entitled to any refund of any premiums or amounts due that was withdrawn by Flexicare whilst this authority and mandate was in force if such premiums or amounts were legally owing to Flexicare in terms of the agreement.
- Acknowledge that by signing this authority and mandate I am bound by the payment terms applicable to this agreement.
- Acknowledgement that this Authority may be assigned to a third party if this agreement is also assigned to a third party.

Reference number

This Agreement reference number: System generated reference number

Abbreviated name

Abbreviated name: DHFLEXCAR

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

In addition to the above terms, the account holder must agree to the following:

- I confirm that I have the right to give Flexicare 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 Flexicare to the account as listed above should this account have insufficient funds, be incorrect or be held in the name of any other person.
- I hereby authorise Flexicare to verify the banking details as provided above for the purpose of setting up a debit order, in need.
- I confirm that the account listed above complies with the Financial Intelligence Centre Act ("FICA").
- I confirm that if I miss a premium collection date, I authorise that Flexicare may deduct a double debit of my premiums the following month

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

Signed at (town or city) _____

Signature of account holder _____

on

D D M M Y Y Y Y



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

This form is only a complete application when it contains all the information we need to fully process your application. We take the date on which we receive the complete application as the application date, and not the date on which you sign the form.

5. Your financial adviser's details (to be completed by your financial adviser)

Where you assisted by a financial adviser? Yes ☐ No ☐

Financial adviser's name _____ Code _____

Intermediary house _____ Code _____

Financial adviser's telephone number (W) _____ Lead number _____

Email _____

Bank reference number (if applicable) _____ (Mandatory for all ABSA and FNB financial advisers)

Declaration

I declare that I have read, understood and agree to the broker declaration on www.discovery.co.za/portal/rules.

I declare that:

- 5.1. I am an accredited financial adviser in terms of the Medical Schemes Act and licensed by the Financial Services Board in terms of the Financial Advisory and Intermediary Services Act at the date of signing this application form.
- 5.2. I am appointed by the employer to provide advice about this application.
- 5.3. I have a valid contract with Flexicare and I have made the client aware of the commission payable Flexicare.
- 5.4. I am responsible for providing the employer and its employees with:
 - my name, physical address, postal address and telephone number.
 - impartial advice that is in his or her best interest.
- 5.5. I am accountable for any advice given to the organisation and its employees about completion of this application form and joining Flexicare.

Signature of financial adviser _____



Please only sign if information is true, complete and correct.

6. Terms and Conditions

- 6.1. You confirm that you have read and understood the Flexicare employer contract and you agree to be bound thereby.
- 6.2. You understand that the information provided to Flexicare in this Information Form will be regarded as personal information as envisaged in the Privacy Statement and the Flexicare employer contract.

7. Signature

You warrant that you are duly authorised to sign this Information Form on behalf of the Employer and that all information stated on this Information Form is true, correct and complete.

Signed at _____ on D D M M Y Y Y Y

Signature

Designation



Please only sign if information is true, complete and correct.

8. Our Privacy Statement

You can view our Privacy Statement on our website: www.discovery.co.za/corporate/privacy.



Contact us on: **0860 100 404**, P.O.Box 78367, Sandton, 2146, www.aon.co.za

FSP number: 20555; CMS number: ORG895

Follow our [website link](#) for further information on Aon's processing of your personal information

Acknowledgement of appointment

I acknowledge and appoint Aon South Africa (Pty) Ltd as my financial advisor for all matters related to my Gap Cover Provider.

My ID: _____ and policy number: _____

Signed at (Town or City): _____ on yy/mm/dd: _____

I have been informed that there is no additional fee charged by Aon for providing you with healthcare intermediary services. Aon earns monthly commission which is already included in the monthly contribution you pay over to the Gap Cover Provider. Monthly commission is part of your total monthly contributions paid to the Gap Cover Provider. This monthly commission is limited to 20% of the monthly contribution to a maximum amount payable (as disclosed on the Brokers Statutory Notice) to brokers in terms of Short-term Insurance Act 53 of 1998, plus Value Added Tax (VAT).

Monthly premium band	Maximum Commission Level
Above R1 200	5 %
R601 to R1 200	10 %
R300 to R600	15 %
Less than R300	20 %

Permission to process my personal information as well as personal information of all dependents included on my membership application form and I consent to Aon South Africa (Pty) Ltd accessing information listed on the table below.

I give consent for the disclosure of information about me.

Policy no: _____ ID or passport no: _____

Gap Provider: _____ Aon Broker Code: _____

Title: _____ Initials: _____ Surname: _____

First name(s) (as per identity document): _____

The following information should be made available to my appointed Broker as is necessary:

Personal examples	Benefit examples	Financial examples	Medical examples
Policy number Date of birth ID number Postal and e-mail Address Physical address Contact details	Type of cover Waiting period details	Total monthly premiums	Claims statement from Medical Scheme and / or Gap Cover Insurance Claims statement from provider



By signing this letter of appointment , I confirm that I have fully read and understood the contents of this document and provide my express consent for Aon South Africa (Pty) Ltd ("Aon") to process my Personal Information including but not limited to special personal information, as well as that of my beneficiaries and where necessary including my minor children (as defined in the Protection of Personal Information Act no 4 of 2013) for the purposes set out herein and which Personal Information may be shared and or disclosed with any party including but not limited to service providers who Aon (in it's reasonable discretion) has an obligation or requirement to share or disclose my Personal Information and that of my beneficiaries and where necessary my minor children in compliance with its obligations in law or contract.

Signed at (Town or City): _____ on yy/mm/dd: _____

Signature: _____



Benefits of appointing Aon South Africa Healthcare as your intermediary

Aon Healthcare is committed to providing you with exceptional service at every interaction. We have a team of professional, fully accredited advisors to assist you with all your medical schemes, Gap cover and Primary care enquiries.

Our philosophy is to:



Guide:

our members in selecting the medical scheme, Gap cover insurance or Primary care options aligned to their needs.



Educate:

our members with ongoing training throughout the year, end of year medical schemes and Gap cover benefits and rate changes.



Protect:

the rights of members by applying the Medical Scheme Act and scheme rules when resolving disputes with the medical schemes on behalf of the members.

Catalogue of services and technological platform accessible to our members

- **Microsites:** Provides you with access to voice recorded Induction, Year-end renewal, Year-end launch highlight presentations, brochures, COVID-19 updates, various application forms.
- **Aon Resolution Centre:** Professional assistance with your Medical scheme, Gap cover or Primary care claim resolution, comparison or benefit explanation.
- **Year-end renewal communications:** Access to member letters providing updates on the following:
 - **Alert** - Provides high level summary of benefits and rates changes launched by medical scheme, Gap cover insurance as well as Primary care providers.
 - **Member letter** - Provides comprehensive information in relation to the benefits and rates changes implemented by Medical scheme, Gap cover or Primary care provider.
 - **Guidance letter** - Aon generates guidance letters for members that are under or over insured. The purpose of the guidance letter is to guide a member on selecting an appropriate option aligned to his/her needs.
- **Ad-Hoc Alerts:**
 - Ad-hoc updates pertaining to Medical schemes industry or providers specific updates.

Cost of appointing Aon

We are pleased to inform you that there is **no additional fee** charged by Aon when you appoint Aon Healthcare as your Healthcare intermediary. Aon earns monthly commission which is already included in the monthly contribution you pay over to the medical scheme. Monthly commission is part of your total monthly contributions paid to the scheme whether you have appointed Aon as broker or not. This monthly commission is 3% of the contribution to a maximum amount payable (as disclosed on the Brokers Statutory Notice) to brokers in terms of Section 65 of the Medical Schemes Act, 131 of 1998, plus value added tax (VAT). In terms of Primary Care Insurance products we earn maximum 3%. Gap Cover Insurance products, we earn commission on a sliding scale from 5% up to 20% depending on policy holder's monthly contributions.

Connect with us

We focus on communication and engagement, across insurance retirement and health, to advise and deliver solutions that create great client impact. We partner with our client and seek solutions for their most important people and HR challenges. We have an established presence on social media to engage with our audiences on all matters related to risk and people.

For more information from Aon Employee Benefits on healthcare, retirement benefits and a wide range of topics feel free to go to www.aon.co.za



<http://www.facebook.com/Aonhealthcare>
Click "Like" on our page (Aon healthcare)



http://twitter.com/Aon_SouthAfrica
Click "follow" on our profile

Aon Employee Benefits – Healthcare

Aon South Africa Pty Ltd, an Authorised Financial Service Provider, FSP # 20555.

<http://www.aon.co.za/disclaimer>

On all services provided, Aon's Terms & Conditions of Business, as amended from time to time, are applicable and can be found at

<http://www.aon.co.za/terms-of-trade> or will be sent to you upon request.

[Privacy Notice](#)

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Disclaimer:

Although care is taken to represent the rates and benefits correctly, errors and omissions could occur. In case of any conflict, the rules of the affected medical scheme prevail. Any decisions regarding your medical scheme portfolio should be made in conjunction with your Aon Employee Benefits consultant or manager. While Aon has taken reasonable steps to ensure that the information contained in this report is relevant, accurate and current, no warranties of any kind, whether express or implied, including but not limited to the accuracy, completeness, relevance or fitness for a particular purpose are given and Aon expressly disclaims any liability for any loss or damage that may arise from the use of this report. This report is confidential and intended solely for the use of the individual or entity to whom it is addressed. If you received this report in error, you should not disseminate, distribute or copy this report and you should notify Aon if you are not the intended recipient and destroy the report. The report is copyright of Aon SA (Pty) Ltd. You may not, except with our express written permission, distribute or commercially exploit the report. Aon hereby authorizes you to copy the report for non-commercial use within your organization only.

POPIA

Protection of Personal Information Act 4 of 2013 (POPIA), Medical Schemes are requesting a signed Broker Appointment letter to make certain information available to Aon South Africa (Pty) Ltd.