

FORM TO CHANGE BANKING DETAILS

What you must do

- Please go through these two steps:
- Step 1: Fill in the form from **step 1-5**.
- Step 2: Sign the application at **step 6 and 7**.

How to complete this form

- To avoid administration delays, please make sure this form is completed in full.
- Once completed, please e-mail your form to [membership@bestmed.co.za](mailto:membership@bestmed.co.za)

Your banking details will only be changed if:

1. The information on this form matches the information on Bestmed's records at the moment.
2. This form has been signed by the principal member as well as the account holder, if different.

NOTE : PLEASE ATTACH THE FOLLOWING

*NOTE: Proof of bank account not older than 3 months must be attached hereto for verification purposes*

1. BANK DETAILS TO BE CHANGED

Contributions

Claims

All

2. PRINCIPAL MEMBER'S DETAILS

Membership number

ID number

Cellphone numberTelephone number

E-mail

I,

(Name & surname) as principal member give Bestmed permission to change my banking details.

3. PREVIOUS ACCOUNT DETAILS

Account holder

Bank

Branch nameBranch code

Account number

Type of account

Cheque

Savings

#### 4. NEW ACCOUNT DETAILS

Effective date for change	<table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y	* Debit order deduction date	<table><tr><td>20<sup>th</sup></td><td>25<sup>th</sup></td><td>1<sup>st</sup></td></tr></table>	20 <sup>th</sup>	25 <sup>th</sup>	1 <sup>st</sup>																
D	D	M	M	Y	Y	Y	Y																							
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Account holder name	<table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																													
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Select account holder	<table><tr><td>Member</td><td>*Company</td><td>*Other</td></tr></table>		Member	*Company	*Other																									
Member	*Company	*Other																												

**\*If you have selected "COMPANY" or "OTHER" please complete the sections below, including the address section. This is in accordance with SARS legislative requirements.**

##### COMPANY

Registered name of company	<table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																																							
Type of company (e.g. private)	<table><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																																							
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##### OTHER

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##### CLAIMS REFUND BANKING DETAILS

Is your claims refund banking details the same as your monthly contributions banking details	<table><tr><td>Yes</td><td>No</td></tr></table>		Yes	No																																				
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If you selected NO, please complete your claims refund banking details below																																								
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## 5. RELATIONSHIP OF ACCOUNT HOLDER TO MAIN MEMBER

[illegible][illegible]

D	D	M	M	Y	Y	Y	Y
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Signature of account holder

- Permission to Change Banking Details Form 2024-09-11 BMF-1301 V4.00

3. In as far as I provide Bestmed with the Personal Information of any third party, including my spouse(s), children or other dependants, I hereby warrant that I have acquired the consent of such third party to do so and in the event of that individual being a child, I do so in my capacity as a "competent person" in respect of such Personal Information, as contemplated in terms of the provisions of POPIA.

Accordingly, I hereby indemnify and hold Bestmed harmless against any claims of whatever nature that may arise as a result of the processing of any Personal Information as provided by myself, for purposes of my membership with Bestmed.

4. Bestmed may identify other products and services which might be of interest to me, as well as to inform me of such products and/or services.

Yes	No
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Signature of principal member