Contact centre: 0860 002 101
Head office: 012 845 0080
General enquiries: service@alliancemidmed.co.za
Authorisation enquiries: auths@alliancemidmed.co.za
Clinical enquiries: clinical@alliancemidmed.co.za
www.alliancemidmed.co.za

ALLIANCE-MIDMED MEDICAL SCHEME

BANKING DETAILS

Claims reimbursements - Reimbursements will only be paid directly into the nominated bank account. Claims can not be reimbursed if details are incorrect or not provided. Please attach an original or certified copy of your bank statement - not an internet bank statement or cancelled cheque - to verify your bank account details; alternatively we will accept a signed and stamped letter from the bank confirming your bank account details.

Name of practice/main member							
Practice/member number							
Name of account holder							
Name of financial institution							
Account number							
Account type		Current		Savings		Transmission	
Branch name			Branch code				

I understand that by providing these details, I authorise the Scheme to pay claim reimbursements directly into this bank account. I will not hold the Scheme responsible for incorrect details provided and agree to inform the Scheme in writing of any changes to these details.

Holder _____ Date D D M M Y Y Y Y

Contribution debit order details - Please submit original proof of banking details for debit order - If employer is responsible for paying contributions. Please attach an original or certified copy of your bank statement. (Not an Internet bank statement or cancelled cheque) to verify your bank account details; alternatively we will accept a signed and stamped letter from the bank confirming your bank account details.

Membership number							
Name of account holder							
Name of financial institution							
Account number							
Account type		Current		Savings		Transmission	
Branch name			Branch code				

I request and authorise the Scheme to debit this account with the amount due under contract in accordance with the Sheme's debit order system. I will not hold the Scheme responsible for incorrect details provided and agree to inform the Scheme in writing of any changes to these details. I understand that contributions are payable monthly in advance and understand it is my sole responsibility to ensure monthly contributions are made. I accept that non-receipt of a single contribution will result in immediate suspension of benefits. This suspension will last until I have paid all contributions in arrears. I accept that non-receipt of two consecutive months contributions will result in the termination of membership.

Email address			
Telephone number		Fax	
Postal address			
		Code	

Date D D M M Y Y Y Y

_____
Name of authorised signatory

PLEASE NOTE: THE SCHEME, THE TRUSTEES AND THE ADMINISTRATORS WILL NOT BE HELD RESPONSIBLE FOR ANY INCORRECT DETAILS SUPPLIED. WE REQUIRE SIGHT OF THE ORIGINAL DOCUMENT OR AN ORIGINAL CERTIFIED COPY OF THE DOCUMENTATION DETAILED ABOVE. A FACSMILE COPY OR PHOTOCOPY WILL NOT BE ACCEPTED.