



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. Mark with an X where necessary.

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 X)	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 X)

Broker/Consultant	Employer Group	Member
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SECTION D

COMPANY PAYMENT DETAILS

Method of Payment: (Mark with an X)

EFT

ACB

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 X)	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, CANCELLED CHEQUE 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.

COMPANY STAMP

If no Company Stamp is available, please mark this block with an X.

Signature of Authorised Company Representative: _____ Date:

D	D	M	M	Y	Y	Y	Y
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SECTION F

BROKER CONSULTANT

Brokerage Name:																				
Broker Code:																				