



Email: polmedmembership@medscheme.co.za • Fax: 0861 888 110

I hereby instruct Medscheme to electronically collect contributions and to deposit claim refunds via the Electropay system. I understand that transfers cannot be done to and from credit card accounts. I also irrevocably authorise Medscheme to adjust any incorrect transactions and/or correct any electronic transfer of funds error without prior notice.

Personal Membership Details

Membership Number

Initials _____ Title/Rank (Mr, Mrs, Miss) _____ ID Number

Surname _____

First Name (in full) _____

Contact Details

Telephone (Home) _____ Cellphone _____

Telephone (Work) _____ Fax _____

Email _____

Postal Address _____

_____ Code _____

Residential Address _____

_____ Code _____

Use this Account for Contribution Collections and for Claim Refunds

Name of Bank

Name of Branch (where account is held)

Branch Number

Type of Account Cheque/Current Savings Transmission

Name of Bank Account Holder

(as it appears on a bank statement)

Bank Account Number

NOTE: For a cheque account/savings account/transmission account, please provide a copy of a recent bank statement. Alternatively, you may submit a stamped letter from your bank confirming the bank account details provided above. A copy of the account holder's ID must accompany this application.



Use this Account for Contribution Collections Only

Name of Bank

Name of Branch (where account is held)

Branch Number

Type of Account Cheque/Current Savings Transmission

Name of Bank Account Holder (as it appears on a bank statement)

Bank Account Number

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Signature of Bank Account Holder _____

Date