MEDSHIELD
medical scheme

REQUEST FOR CONTRIBUTIONS REFUND

Please complete all the relevant sections of this form in BLOCK LETTERS.
The completed form, together with any relevant documentation, must be e-mailed to creditcontrol@medshield.co.za

Membership Number:

SECTION A

TO BE COMPLETED BY THE PRINCIPAL MEMBER OF THE SCHEME

Please note: Dependant ID numbers are only required if you are an active member of the Scheme.
No need to complete the dependant section if you are a terminated member

Principal Member Name:
Principal Member Surname:
Principal Member ID Number:
Principal Member Cell Number:
Principal Member Email Address:
Dependant ID/Passport Number:
Dependant ID/Passport Number:
Dependant ID/Passport Number:
Dependant ID/Passport Number:
Dependant ID/Passport Number:

SECTION B

REFUND DETAILS

Please enter the contribution amount due as reflected on your last statement received. If there is no contribution amount reflected on your last statement received, please briefly describe your refund request and the period affected.

Last Statement Date: D D M M Y Y Y Y
Contribution Balance: R
Refund Details Description:

SECTION C

REFUND BANK DETAILS

PLEASE PROVIDE BANKING DETAILS OF THE PERSON THAT THE REFUND IS PAYABLE TO.
Please provide a copy of your latest stamped confirmation of bank account letter (Name and account holder and the date when the account was opened must be clear on the letter), and a copy of the Principal Member's identity document and the account holder's identity document, if they differ. Refunds for debit order members will be paid into the same account where we received the debit order payment from.

Bank Account Holder:
Bank Name:
Branch Name:
Branch Code:
Type of Account: (Mark with an X) Current Transmission Savings
Bank Account Number:

SECTION D MEMBER DECLARATION

I, _____ (Principal Member's full name) the undersigned, upon receiving my signed form, hereby give Medshield Medical Scheme the authority to refund my contributions balance on my request. I acknowledge that:

The details contained herein are true and accurate;

- I hereby authorise the Scheme, or any of its nominated representatives, to verify the bank details and identity document(s).
- I am aware that this form must be received by Medshield Medical Scheme before the refund is authorised.
- I confirm that I will not request a stop payment with my bank for any amounts collected via debit order or via Persal if my contributions are paid via Persal.
- I will be liable for any refund amount refunded to me in error.

_____

Principal Member Signature

Date: | D | D | M | M | Y | Y | Y | Y |