Please select what type of Practice this is:

Cash ☐ EFT ☐

If this is a **Cash Practice**, please **ONLY** complete this section and return to us.

Practice Name

Practice Number

Date _____ Signature_____

ONLY complete the ElectroPay form below if you require payment to be made into your Bank account (EFT)

Dear Healthcare Professional,

In order to process your application to transfer payments into your **Bank account**, please provide Medscheme with the relevant documents:

1. The original completed **Electropay** form **signed by the Healthcare Professional**.
2. A copy of the **identity document** for the **Healthcare Professional signing this form.**
3. Original proof of bank details:
   - For a **cheque account**, attach an **original cancelled cheque** or **an original bank letter**. (No copies or certified copies will be accepted)
   - For a **savings or current account**, please provide **an original signed letter** on an official letterhead from your bank or financial institution.

If the name of the practice and the name of the bank account holder **is not the same**, please complete the **Affidavit (page 2)** signed by the signatory and also attach **an original certified copy of identity document**. In addition, please complete the **Affidavit (page 2)** if the account holder/practice name is **Incorporated** or reflects the practice name as **Trading as (t/a)**. In this instance the signatory will also need to attach **an original certified copy of identity document**.

PLEASE NOTE: A telephonic verification will be conducted with the HCP before banking details are loaded.

N.B Non compliance will result in documents being returned for resubmission. Failure to comply with ALL of the requirements will delay payments into bank accounts.

I hereby instruct Medscheme to electronically remit this practice, via Electropay, using the following account details. I understand that funds cannot be transferred into credit card accounts.

Practice Number

Practice Name

Name of Bank

Name of Branch (Where account is held)

Branch Code

Type of Account: Cheque/Current ☐ Savings ☐ **VAT No.**

Name of Bank Account
(As it appears on Bank letter/Statement or Cancelled cheque)

Bank Account Number

Full Name of Healthcare Professional (Who warrants that he/she is duly authorised hereto)

Date _____ Signature_____

If the name of the practice and the name of the bank account holder **is not the same**, please complete the **Affidavit** signed by the signatory and also attach **an original certified copy of identity document**. In addition, please complete the **Affidavit** if the account holder/practice name is **Incorporated** or reflects the practice name as **Trading as (t/a)**. In this instance the signatory will also need to attach **an original certified copy of identity document**. In completing the affidavit, the commissioner of oaths certifying the documents must complete, stamp and sign the "certification of document" block in full.

Affidavit

I (full names)

I.D Number

Require that Medscheme transfer funds from practice number into the bank account of

Name of Bank Account
(As it appears on Bank letter/Statement or Cancelled cheque)

Bank Account Number

Healthcare Professional Signature _____

As a listed Company, Medscheme adheres to anti-fraud measures as contained in the following Acts, Prevention of Organised Crime Act, Protected Disclosure Act, Financial Intelligence Centre Act, Prevention and Combating of Corruption Act, Companies Act & Regulations, therefore, ALL documents pertaining to banking details to be commissioned/certified by the South African Police Service (SAPS).

Please complete block in full and stamp

CERTIFIED TRUE COPY OF THE ORIGINAL DOCUMENT. THERE ARE NO INDICATIONS THAT THE ORIGINAL DOCUMENT HAS BEEN ALTERED BY UNAUTHORISED PERSONS.

Designation (rank)_____ex officio: Republic of South Africa

Date: _____

Place _____

Business Address: _____

_____

Commissioner of Oaths

_____

SIGNATURE FULL NAMES

COMMISSIONER
OF
OATHS
STAMP
HERE

To ensure that we have your correct practice contact details, please complete the fields below:

Telephone Number (W) _____ Cell number _____

Facsimile _____ Email _____

Postal Address _____

_____

Healthcare Professional Contact Centre number: 086 111 2666 Website: www.medscheme.co.za

Post ALL documents by registered mail to: Medscheme Electropay, PO Box 2825, Durban, 4000
Courier ALL documents to: Medscheme Electropay, 3rd Floor, 67 K.E. Masinga Road, Durban, 4001