4th Floor, The Terraces, Black River Park
Fir Street, Observatory, 7925
P O Box 144, Observatory, 7935
Tel: (021) 442 9900
Fax: (021) 447 4707
e-mail: genesis@genesismedical.co.za
website: www.genesismedical.co.za

ELECTRONIC FUNDS TRANSFER (EFT)

(SERVICE PROVIDERS)

Dear Provider,

Kindly complete the details below, and:

1. Post this **original** form; with
2. An **original** letter on your letterhead requesting the amendment; together with
3. An **original** letter from your bank, bearing their official stamp, or an **original** cancelled cheque reflecting your account number to the Scheme's postal address as listed above.

Please note that faxed or emailed requests/forms will NOT be considered.

Practice Name:	
Practice Number:	
E-mail Address: for statement purposes	
Name of Account Holder: i.e surname, first name & other initials or company name	
ID Number/Company Reg Number:	
Name of Bank:	
Branch:	
Branch Code:	
Account Number:	

Type of Account: (please tick) **Current/ Cheque** ☐ **Savings** ☐ **Other** ☐

I/We, confirm that the above details of my beneficiary bank account are true and correct.

I/We, the undersigned, will not hold Genesis Medical Scheme responsible for any loss, damage or liability which may arise out of the furnishing of incorrect information by me/us and I/we undertake to indemnify Genesis Medical Scheme in respect of any claim, loss or damages that may be instituted against Genesis Medical Scheme arising from the furnishing of incorrect information.

I/We personally undertake to advise Genesis Medical Scheme of any changes, which may occur in the Bank information shown above.

SIGNATURE: _____ **DATE:** _____

FOR SCHEME USE ONLY:
Received By: _____
Date Received: _____
Processed By: _____
Date Processed: _____
Name of the person which the details were verified with: _____