genesis
MEDICAL SCHEME

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# 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:** _____