

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 or statement from your bank, bearing their official stamp and reflecting your account number to the Scheme’s postal address as listed above. Electronic documents bearing an electronic stamp will NOT be accepted.

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

Practice Name:

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Practice Number:

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E-mail Address:

for statement purposes

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Name of Account Holder:

i.e surname, first name & other initials or company name

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ID Number/Company Reg
Number:

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Name of Bank:

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Branch:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Branch Code:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Account Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Type of Account: (please tick)

Current/ Cheque	Savings	Other
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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: _____
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