Request to change banking details 2023

Purpose of the form

The form accommodates banking detail changes for Discovery Health Medical Scheme, Discovery Life, Discovery Insure, Discovery Invest, Discovery Gap and Discovery Supplementary Illness Benefit:

- **Section 1** is compulsory and applies to all change requests where you are the main member/policyholder.
- **Section 2** applies to changes on the **Discovery Health Medical Scheme only** (your medical aid membership)
- **Section 3** applies to changes on Discovery Life, Discovery Insure, Discovery Invest, Discovery Gap and Discovery Supplementary Illness Benefit
- The terms and conditions page must be attached when returning the form as an acknowledgement of the terms for the banking details update
- Please complete section 2 and/or section 3 based on the policies for which you want to update banking details.

How to complete this form

1. Use black ink, write one letter per block (where applicable) and print clearly
2. Read and sign the Terms and conditions in section three
3. Where you need to choose between different options, mark your selection with a (√)

How to submit this form

Email the completed form to **bankingdetails@discovery.co.za**

Supporting documents required

These are listed under each type of account. Attach the relevant documents only and return them with the completed form. We can only change your banking details if you have completed the form, accepted the terms and conditions and submitted all the required supporting documents.

Main member/policy holder account	**If you are updating your own banking details, you do not need to submit supporting documents, as we will verify the banking details with the bank. If we are unable to verify the details, we will need the following documents:** • Proof of account (bank statement or bank letter not older than three months) • A copy of your ID, passport or driver's license
Third party account	• Proof of the account (bank statement or bank letter not older than three months) • A copy of the third party's (account holder) ID, passport or driver's license • A copy of the main member's/policy holder's ID, passport or driver's license
Joint account	• Proof of account (bank statement or bank letter not older than three months) • A copy of the ID, passport or driver's license of each of the joint owners
Trust account	• Proof of account (bank statement or bank letter not older than three months) • A copy of the ID, passport or driver's license of each of the trustees of the account • A copy of the Trust's certificate of registration • A copy of the Trust letter, showing the trustees. The resolution must be dated, signed by an authorized person on behalf of the Trust and it must contain the membership or policy number(s). The letter must give authority that the trust account account can be debited for the specified policy or membership details specified in the letter • A copy of the main member's/policy holder's ID, passport or driver's license
Company account	• Proof of account (bank statement or bank letter not older than 3 months) • A copy of the ID, passport or driver's license of each signatory or person who has authority to sign on behalf of the company • A copy of the main member's ID , passport or driver's license • A letter of authority including the details of all the persons of authority and the policy or membership details the authority applies to. The letter of authority must be signed and dated and give authority that the company account can be debited for the specified policy or membership details specified in the letter • A copy of the company's certificate of registration

If you are completing the application form on behalf of the main member, please include proof that you have obtained the necessary authority (example, Letter of Authority or Letter of Executorship)

Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider and administrator of medical schemes.

SECTION 1 – Details of main member/policy holder

Please complete all the information in this section.

Title | | | | | Initials | | | | |

First name(s)

Surname

Gender Male [ ] Female [ ] Date of birth D D M M Y Y Y Y

ID or passport number Telephone (H) -

Telephone (W) - Cellphone -

Email

Note: Please note that the email address you provide above must be one of the email addresses that we have for the main member or policy holder on our system. If the email address is not on our system, we will not proceed with the update and we will not communicate to that email address. This email address will be used for a once-off communication regarding the banking details update. We will not save the email address you give us on this form to your profile. If you have authority to act on behalf of the main member you can specify the relevant email address that we need to communicate to. You must also submit proof that you are allowed to act on behalf of the main member (example, Letter of Authority or Letter of Executorship).This form is available on the Discovery website **www.discovery.co.za** in the "Update banking details" section. Using the website ensures a quicker, easier change process.

Request to change banking details 2023

Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme.

Contact us

0860 99 88 77, **www.discovery.co.za**, PO Box 784262, Sandton, 2146,1 Discovery Place, Sandton, 2196.

This form is available on the Discovery website **www.discovery.co.za** in the "Update banking details" section. Using the website ensures a quicker, easier change process.

Note: For debit order banking detail changes, we have to receive your request 10 working days before your next debit order date, if not the debit order might still be submitted on the old bank account.

Section 2 - Debit order bank details update for Discovery Health Medical Scheme

Membership number

Please mark the tick box if you would like us to use the debit order banking details for claims reimbursement banking purposes ☐

Bank account details - please note that we cannot accept credit card details for debit order collections.

This is the account we will use to collect premiums, it will also be used to process contribution refunds.

Account owner: Main member ☐ Third party ☐ Company ☐ Joint account ☐ Trust ☐

Bank name

Branch name — Branch code

Account number — Type of account: Cheque ☐ Savings ☐

Title — Initials

First name(s)

Surname

Date of birth D D M M Y Y Y Y — ID or passport number

In addition to the above, please also complete the details below for company or trust accounts.

Company or trust

Registration number

Account holder residential address (if the account holder is a company, please state the company address)

Account holder email address (if the account holder is a company, please state the company email address)

Account holder contact number (if the account holder is a company, please state the company contact number)

As part of Payment Association of South Africa (PASA) debit order mandate requirements you are required to supply the account holders residential address, email address and contact number. Please note that the details you supply will only be used for the PASA debit order mandate requirement and will not be used to update the contact details we have on system, if you wish to update any contact details please visit www.discovery.co.za

Section 3 - Terms and conditions for Discovery Health Medical Scheme

The main member and third party account holder who sign this agreement (referred to as "you") authorise Discovery Health Medical Scheme to deduct the policy contributions from the debit order account.

Authorisation to use the bank account

You must accept these terms and conditions. The third-party debit order account holders must give Discovery Health Medical Scheme written notice if they want to cancel this authorisation.

Payment instructions

The bank listed in this agreement will treat all payment instructions issued in terms of this authorisation as if you personally issued the instructions.

You may cancel this payment instruction. However, such cancellation will not cancel the agreement. You will not be entitled to any refund of amounts withdrawn while the payment instruction was in force.

Payment obligations

You must pay any bank charges for this debit order authorisation or instruction. You will have to pay claims, losses and damages if there are not enough funds in the account, if the account details are incorrect or if the account is held in the name of any other person not included in this Agreement.

Changes to your rights and responsibilities

Discovery Health Medical Scheme, authorised to withdraw money from your account, may not cede (give up or transfer) or assign any of their rights to any other third party without your written permission.

You may not hand over any of your responsibilities in terms of this contract to any other third-party without the authorised party's written permission.

You may request a copy of our full privacy statement. The full privacy statement is also available on our website at **https://www.discovery.co.za/discovery_coza/web/linked_content/pdfs/health/dhms/privacy_statement.pdf**

Section 4 - Debit order mandate

This signed authority and mandate refers to the Agreement.

I, the undersigned:

- Warrant that the account information I have provided above is an account in my name and that the information furnished by me/us in this Agreement is true and correct;
- Authorise Discovery Health Medical Scheme to issue and deliver payment instructions to my bank, recorded above, for the collection by Discovery Health Medical Scheme from the bank account (or any other bank or branch to which I may transfer my account) any amounts due under or in terms of this application on condition that the sum of such payment instructions will never exceed my obligations as framed in the Agreement which shall commence on the date that cover starts as requested on the application form and shall continue until this Authority and Mandate is terminated by me by giving Discovery Health Medical Scheme no less than 20 ordinary working days written notice thereof or immediately in the event that I instruct my bank to withdraw this Agreement.
- Confirm that the payment instructions mentioned above must be issued on the first working day of the month. If the membership is not activated in time for the debit order collection and there is an amount outstanding Discovery Health Medical Scheme can collect that amount in the interim, upon activation. If I change the date of the debit order after activation, I confirm that the payment instructions must be issued and delivered on the day that I have nominated ("payment day") and thereafter on the same day in each and every successive month. If the payment day falls on a Sunday or recognised South African public holiday, the payment day will automatically be the next working day;
- Authorise Discovery Health Medical Scheme to track my bank account and re-present the payment instruction referred to above in the event that there are insufficient funds in my bank account to meet my obligations under or in terms of this Agreement.
- Acknowledge that my bank will treat each payment instruction to pay contributions or amounts due under this Agreement to Discovery Health Medical Scheme as if each payment instruction came from me personally as the account holder.
- Undertake to advise Discovery Health Medical Scheme in writing of any changes to my account details and acknowledge that Discovery Health Medical Scheme will not be held responsible or liable for any claim, loss or harm that I or any third party may suffer as a result of me providing incorrect banking details herein or if the bank account is in the name of another person or entity or as a result of my failure to notify Discovery Health Medical Scheme of a change in banking details or if the bank account has insufficient funds to meet my obligations under or in terms of the Agreement.
- Know and understand that the withdrawals hereby authorized will be processed through a computerized system provided by South African banks. The details of each withdrawal from my bank account will be printed on my bank statement and must show the reference number of the membership inserted in the Agreement so as to enable me to identify this membership;
- Acknowledge that in the event of a termination I am not entitled to any refund of any contributions or amounts due that was withdrawn by Discovery Health Medical Scheme whilst this Agreement was in force if such contributions or amounts were legally owing to Discovery Health Medical Scheme in terms of the Agreement;
- Acknowledge that by signing this Agreement I am bound by the payment terms applicable.

Reference number

This Agreement reference number is DISC PREM/DISCSETTLE

Deduction date: as per signed contract

Deduction amount: as per signed contract

Payment due date: as per signed contract

Signature of bank account holder ____________________ Date D D M M Y Y Y Y

Please only sign if you have read and understood this statement

Please note that this form expires on 31/03/2024. Up-to-date forms are always available on www.discovery.co.za under Medical Aid > Manage your health plan > Find important documents and certificates.

DHMRCB003

Discovery Health Medical Scheme, registration number 1125, is regulated by the Council for Medical Schemes and administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider.

Section 5 - Medical claims refunds - bank-details update for Discovery Health Medical Scheme

Membership number

Please note that you do not have to complete the medical claims refund section, if you have indicated in the debit order account section that the same details should be used for claims refund purposes.

Account owner — Main member ☐ Third party ☐ Company ☐ Joint Account ☐ Trust ☐

Bank name

Branch name — Branch code

Account number — Type of account — Cheque ☐ Savings ☐

Title

First name

Surname

Date of birth D D M M Y Y Y Y — ID or passport number

In addition to the above, please also complete the details below for company or trust accounts.

Company or trust

Registration number

Signature of account holder

Please only sign if you have read and understood this statement

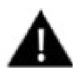
In addition to the above terms, the main member or their proxy and bank account holder must agree to the following

1. I confirm that I have the right to give Discovery Health Medical Scheme the authority to debit such account on a monthly basis. Furthermore, I will be liable for any claims, losses or damages of whatsoever nature arising out of debits made by Discovery Health Medical Scheme to the account as listed above should this account have insufficient funds, be incorrect or be held in the name of any other person.
2. I hereby authorise Discovery Health Medical Scheme to verify the banking details as provided above for the purposes of setting up the debit order, in need.
3. I confirm that the account listed above complies with the Financial Intelligence Centre Act (“FICA”).
4. I confirm that if I miss a contribution collection date, I authorise that Discovery Health Medical Scheme may deduct a double debit of my contributions the following month

I, ______ (full name(s) and surname, according to your identity document), as the main member, give Discovery Health Medical Scheme permission to change my banking details.

Signed at (town or city)

Signature of policyholder — Date D D M M Y Y Y Y



Please only sign if you have read and understood this statement