EMPLOYER **BANKING DETAILS**

PO Box 2338, Durban 4000 | Tel: 0861 000 300 | Fax: 031 580 0478 | Email: membership@mhcmf.co.za

moto HEALTH CARE
taking care of our own

Employer number

Employer name

Telephone number

Name of account holder

Name of bank

Branch name

Branch code

Account number

Type of account Current ☐ Savings ☐

PLEASE DO NOT PROVIDE CREDIT CARD DETAILS. MOTO HEALTH CARE IS NOT ALLOWED TO RECORD YOUR CREDIT CARD DETAILS.

Your details will only be processed upon receipt of a valid copy of your identity document, together with a certified letter from your bank validating your banking details; alternatively the bank will need to stamp this completed form.

We authorise Moto Health Care to debit the above account with the contributions due on the first working day of every month. I/We understand that Moto Health Care bills for contributions in arrears.

We accept that if the company's contributions are not paid by the due date, the Scheme will suspend benefits with immediate effect. If the contributions are not paid within 30 days from the suspension date, the company and all Moto Health Care members will be terminated.

We confirm that we have an arrangement in place with every employee who is a member of Moto Health Care whereby we will recover amounts due to the Scheme from such member's income.

We shall give the Scheme one month's written notice of our intention to withdraw our participation in the Scheme. We acknowledge that failure to give proper notice will result in the full month's contribution becoming immediately due and payable.

Please supply a current stamped bank statement for verification of banking details.

Name and surname

Date

DD/MM/YYYY

Designation

Name and surname

Date

DD/MM/YYYY

Designation

Where applicable, a resolution confirming the signatories that are authorised to sign documents on behalf of the employer must be attached.

Authorised signatories

Date

DD/MM/YYYY

Date

DD/MM/YYYY