BANKING DETAILS FOR INDIVIDUALS

moto HEALTH CARE
taking care of our own

PO Box 2338, Durban 4000 | Telephone: **0861 000 300** | Email: **membership@mhcmf.co.za**

Please note: The Scheme reserves the right to request additional information if required. All personal information recorded on this form and submitted to us, shall be processed by Moto Health Care in accordance with the law and the Scheme's Privacy Policy, which is available on the website (www.mhcmf.co.za), or on request from our call centre (0861 000 300).

MEMBERSHIP DETAILS

Membership number			
Name and surname			
Identity/Passport number		Contact telephone number	
Email address			

BANKING DETAILS

Important note: Your details will only be processed upon receipt of a valid copy of your identity document, together with a letter stamped by your bank validating your banking details; alternatively the bank will need to stamp this completed form. Please do not provide credit card details. Moto Health Care cannot process debit orders from your credit card.

Name of account holder			
Name of bank			
Account number		Branch name	
Branch code		Type of account	

☐ Please use these banking details to debit my monthly contributions.

☐ Please use these banking details to pay any refunds due to me.

Please supply the following documents (not older than three months) to validate your banking details:

- Certified copy of your identity document (ID)
- Account confirmation letter from your bank **or** a stamped bank statement.

Signature of account holder
(if account does not belong to the principal member)

Date DD/MM/YYYY

MEMBER DECLARATION

- I hereby instruct and authorise Moto Health Care to debit any amounts which may be due by me from my abovementioned bank account.
- I hereby instruct and authorise Moto Health Care to credit any amounts which may be due to me to my abovementioned bank account.
- I understand that the debit/credit transfers hereby authorised will be processed electronically and that details of each debit/credit transaction will appear on my medical claims statement.
- I understand that the Scheme will provide me with billing statements and that any authorised debit order will be actioned at least 10 days after the date of statement. Should I have any reason to disagree with the statement and do not want the debit order to be actioned, I agree to contact the Scheme on **0861 000 300** so that alternate arrangements can be made.
- I agree to pay any bank charges relating to the debit order instruction.
- I understand that I may cancel this authorisation by giving 30 days' written notice to the Scheme, but that I may not be entitled to any refund for amounts which may have been withdrawn from my account while this authority was in force, if such amounts were legally owed by me.
- I hereby agree to inform the Scheme if any of my banking details may change.

Signature of principal member **(mandatory)**

Date DD/MM/YYYY