EMPLOYER BANKING DETAILS

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

moto HEALTH CARE
taking care of our own

EMPLOYER INFORMATION

Employer number	
Employer name	
Contact telephone number	

BANKING DETAILS

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

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

- Certified copy of the identity document (ID) of the authorised signatory i.e., the person responsible for the employer's bank account
- Account confirmation letter from your bank
- A stamped bank statement.

EMPLOYER DECLARATION

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

We accept that if the employer'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 employer and all Moto Health Care members/employees' membership 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.

We, the undersigned, declare that we are duly authorised to complete this application form on behalf of the employer and that the details provided herein are true and correct.

If applicable, please provide supporting documentation confirming that these signatories are duly authorised to represent and sign on behalf of the employer.

Signed on behalf of the employer		Date	DD/MM/YYYY
Name and surname of authorised signatory			
Designation			

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Name and surname of authorised signatory			
Designation			