genesis
MEDICAL SCHEME

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ELECTRONIC FUNDS TRANSFER (EFT)

(SERVICE PROVIDERS)

Dear Provider,

Kindly complete the details below, and:

1. Mail this **original** form; with
2. An **original** letter on your letterhead requesting the amendment; together with
3. An **original** letter from your bank, bearing their official stamp, reflecting your account number to the Scheme's postal address as listed above.

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

Practice Name:

Practice Number:

E-mail Address:

Name of Account Holder:
i.e Surname, first name & other initials or company name

I.D. Number / Company Reg Number

Name of Bank:

Branch:

Branch Code:

Account Number:

Type of Account: (please tick)

Transmission		**Current/ Cheque**		**Savings**	

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: _____