BANK DETAILS CHANGE FORM

GapCover®
medical shortfall solutions

Email: admin@insuremed.co.za / Fax: 0865 846 398

NB: Notice of a change in bank details must be received by the 20th of a month to be effective from the 1st of the following month.

A PRINCIPAL MEMBER DETAILS

Title: ______ Initials: ______ Surname: ______

ID/Passport No: ______ Passport No: ______

Policy No: G A P ______ Medical Scheme: ______

B PRINCIPAL MEMBER DETAILS

Telephone (W): ______ Fax No: ______

Telephone (H): ______ Cell No: ______

Email Address: ______

Postal Address: ______

Postal Code: ______

Home Address: ______

Postal Code: ______

C BANKING DETAILS (DEBIT ORDER)

Account Holder Name: ______ Account Holder Contact Number: ______

Name of Bank: ______ Branch Code: ______

Account No: Debit ______ Account type: Cheque | Current | Savings | Transmission

Order Date: Effective 1st | 5th | 10th | 15th | 25th

From: 0 1 M M 2 0 Y Y

I, Full Name hereby authorise the deduction of my monthly contribution for GapCover®.

I acknowledge that these premiums will be deducted monthly from the account above on the selected debit order date.

Date: D D M M Y Y Y Y Signature of Account Holder: ______

Date: D D M M Y Y Y Y Signature of Principal Member: ______

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