Employer Information Form for Flexicare 2024

flexicare
Powered by Discovery

Contact us

Tel: 0860 444 779; 1 Discovery Place, Sandton, 2196; PO Box 784262, Sandton, 2146; www.discovery.co.za

Who we are

Flexicare is not a medical scheme. The cover is not the same as that of a medical scheme and is not intended to be a substitute for medical scheme membership. Flexicare is administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07 an authorised financial services provider and underwritten by Auto & General Insurance Company Limited, registration number 1973/016880/06, an authorised insurer and financial services provider. Terms, conditions and limits apply.

What you must do

- Fill in the form in black ink and print clearly or complete the form digitally.
- This form ("the Information Form") must be completed and returned to Flexicare together with the signed Flexicare employer contract for registration of the Product. The signed quotation, this Information form and the employer contract together will constitute your agreement with Flexicare for the Product.
- Sign section 6. This section must be physically signed and may not be signed digitally.
- Email the signed employer contract and this Information form to **GroupApplication@discovery.co.za**

1. About your organisation

When do you want your cover to start? D D M M Y Y Y Y

Name of employer

Registration number | Employer number

VAT number | Branch number

Legal entity, for example (Pty) Ltd,

Physical address

Suite number | Complex name

Street number | Street name

Suburb | Postal code

Postal address (Post collected from post box, suite or private bag)

If you do not complete a postal address, we will use your physical address for the post.

☐ PO Box ☐ Private Bag Box number

☐ Suite ☐ Postnet Suite Number

Suburb | Postal code

In what industry do you operate? Please tick the applicable block.

☐ Mining and mining resources ☐ Financial Services ☐ Retail ☐ Construction/building ☐ Manufacturing

☐ Hotel/leisure/entertainment ☐ Professional services ☐ Education ☐ Religious organisations ☐ IT

Other (please specify)

COID (workman's compensation) registration number

2. Your organisation's contact person

2.1. Contact person (This is the Employer contact person who is authorised to deal with us and send us financial and other changes for your Employees)

Title | Initials

Surname

First name(s) (as per identity document)

ID or passport number | Employee number

Telephone (H) | Telephone (W)

Cellphone | Fax

Email address

3. Banking details for your monthly contributions (if applicable)

You may only provide a South African bank account. Payment of all fees will be in advance and by means of a debit order, unless you have an existing payment arrangement with Discovery Health, in which case that payment arrangement will also be applied to the fees payable in terms of this product. If the product is not activated prior to the debit order submission, the initial fee will be included in the following month's debit order.

Please note: We do not accept credit card details and you can only use a South African bank account.

Bank name

Branch name | Branch code

Account number | Type of account | Cheque | Savings

Name of account holder

Authorised signatory (ies) on behalf of the employer and employees duly authorised:

Name(s) | Name(s)

Designation(s) | Designation(s)

4. Flexicare Debit Order Mandate

Note: If the request to change bank details is submitted within five days from the next debit order date, the debit order might still be submitted on the old bank account as we need a minimum of five days' notice to update bank details.

Supporting documents required

Please send the signed Request To Change Bank Details Online Mandate back to us with the documents under each type of bank account. Please only send the documents relevant to your update. These documents are only applicable or needed when you are using one of the bank account types listed below.

When using **another contact persons bank account** (for example, spouse, aunt, uncle, friend, father, son):

- Proof of the account, like a copy of the bank statement, not older than three months.
- A copy of the ID, passport or drivers license of the employer and bank account owner.

When using a **joint account:**

- Proof of the account, like a copy of the bank statement or letter from the bank on a bank letterhead (the proof must not be older than three months from the day that you send it to us)
- A copy of the ID, passport or drivers license of each of the joint account owners

When using a **company account:**

- Proof of the account, like a copy of the bank statement or letter from the bank on a bank letterhead (the proof must not be older than three months from the day that you send it to us)
- A copy of the ID, passport or drivers license of each signatory or person who has authority to sign on behalf of the company
- A letter of authority including the details of all the persons of authority and the policy or membership details
- A copy of the company's certificate of registration

When using a **trust account:**

- Proof of the account, like a copy of the bank statement or letter from the bank on a bank letterhead (the proof must not be older than three months from the day that you send it to us)
- A copy of the ID, passport or drivers license of each of the trustees of the account
- A copy of the trust's certificate of registration
- A copy of the trust resolution, showing the trustees

If you have staff members on one of the medical schemes administered by Discovery Health, we will align the billing method to the scheme's. If you are currently a cash payer, you can choose to pay for Flexicare through a debit order, where your premiums will be deducted through a debit order, please complete the below details:

Name of accountholder

Address

Bank

Branch and code

Account number

Type of account

Amount **R** . Date D D M M Y Y Y Y

To: (*name of beneficiary*)

Terms and conditions

This signed authority and mandate refers to the application on the signed date ("the agreement")

I/We, the undersigned:

- Warrant that the account information I/we have provided above is an account in my/our name and that the information furnished by me/us in this authority and mandate is true and correct.
- Authorise Flexicare to issue and deliver payment instructions to my bank, recorded above, for the collection by Flexicare from the bank account (or any other bank or branch to which I may transfer my account) any amounts due under or in terms of this application to change banking details on condition that the sum of such payment instructions will never exceed my obligations as framed in the agreement which shall commence on the date that the banking details are effective and shall continue until this authority and mandate is terminated by me by giving Flexicare no less than ordinary working days written notice thereof or immediately in the event that I instruct my bank to withdraw this authority and mandate.
- Confirm that the payment instructions mentioned above must be issued on the first working day of the month. If the change in banking details are not activated in time for the debit order collection and there is an amount outstanding, Flexicare can collect that amount in the interim, upon activation of the banking details. If I change the date of the debit order after activation of the banking details, I confirm that the payment instructions must be issued and delivered on the day that I have nominated ("payment day") and thereafter on the same day in each and every successive If the payment day falls on a Sunday or recognised South African public holiday, the payment day will automatically be the next working day.
- Authorise Flexicare to track my bank account and re-present the payment instruction referred to above in the event that there are insufficient funds in my bank account to meet my obligations under or in terms of this agreement.
- Acknowledge that my bank will treat each payment instruction to pay premiums or amounts due under this agreement to Flexicare as if each payment instruction came from me personally as the account holder.
- Undertake to advise Flexicare in writing of any changes to my account details and acknowledge that Flexicare will not be held responsible or liable for any claim, loss or harm that I or any third party may suffer as a result of me providing incorrect banking details herein or if the bank account is in the name of another person or entity or as a result of my failure to notify Flexicare of a change in banking details or if the bank account has insufficient funds to meet my obligations under or in terms of the agreement.
- Know and understand that the withdrawals hereby authorised will be processed through a computerised system provided by South African banks. The details of each withdrawal from my bank account will be printed on my bank statement and must show the reference number of the membership inserted in the agreement so as to enable me to identify this membership.
- Acknowledge that although this authority and mandate may be terminated by me, such termination does not necessarily terminate this In the event of such termination, I am not entitled to any refund of any premiums or amounts due that was withdrawn by Flexicare whilst this authority and mandate was in force if such premiums or amounts were legally owing to Flexicare in terms of the agreement.
- Acknowledge that by signing this authority and mandate I am bound by the payment terms applicable to this agreement.
- Acknowledgement that this Authority may be assigned to a third party if this agreement is also assigned to a third party.

Reference number

This Agreement reference number: System generated reference number

Abbreviated name

Abbreviated name: DHFLEXCAR

Deduction amount – as per signed contract

Payment start date – as per signed contract

Signature of bank account holder

Date D D M M Y Y Y Y

Please only sign if you have read and understand this statement.

In addition to the above terms, the account holder must agree to the following:

- I confirm that I have the right to give Flexicare the authority to debit such account on a monthly basis. Furthermore, I will be liable for any claims, losses or damages of whatsoever nature arising out of debits made by Flexicare to the account as listed above should this account have insufficient funds, be incorrect or be held in the name of any other person.
- I hereby authorise Flexicare to verify the banking details as provided above for the purpose of setting up a debit order, in need.
- I confirm that the account listed above complies with the Financial Intelligence Centre Act ("FICA").
- I confirm that if I miss a premium collection date, I authorise that Flexicare may deduct a double debit of my premiums the following month

I _____ (Full name(s) and surname according to your identity document), as the account holder, give Flexicare and its subsidiaries in their relevant capacities permission to change my banking details.

Signed at (town or city) _____

Signature of account holder _____ on D D M M Y Y Y Y

Please only sign if you have read and understand this statement.

This form is only a complete application when it contains all the information we need to fully process your application. We take the date on which we receive the complete application as the application date, and not the date on which you sign the form.

5. Your financial adviser's details (to be completed by your financial adviser)

Where you assisted by a financial adviser? Yes ☐ No ☐

Financial adviser's name _____ Code _____

Intermediary house _____ Code _____

Financial adviser's telephone number (W) _____ Lead number _____

Email _____

Bank reference number (if applicable) _____ (Mandatory for all ABSA and FNB financial advisers)

Declaration

I declare that I have read, understood and agree to the broker declaration on www.discovery.co.za/portal/rules.

I declare that:

5.1. I am an accredited financial adviser in terms of the Medical Schemes Act and licensed by the Financial Services Board in terms of the Financial Advisory and Intermediary Services Act at the date of signing this application form.

5.2. I am appointed by the employer to provide advice about this application.

5.3. I have a valid contract with Flexicare and I have made the client aware of the commission payable Flexicare.

5.4. I am responsible for providing the employer and its employees with:
- my name, physical address, postal address and telephone number.
- impartial advice that is in his or her best interest.

5.5. I am accountable for any advice given to the organisation and its employees about completion of this application form and joining Flexicare.

Signature of financial adviser _____

Please only sign if information is true, complete and correct.

6. Terms and Conditions

6.1. You confirm that you have read and understood the Flexicare employer contract and you agree to be bound thereby.

6.2. You understand that the information provided to Flexicare in this Information Form will be regarded as personal information as envisaged in the Privacy Statement and the Flexicare employer contract.

7. Signature

You warrant that you are duly authorised to sign this Information Form on behalf of the Employer and that all information stated on this Information Form is true, correct and complete.

Signed at _____ on D D M M Y Y Y Y

Signature	
Designation	

Please only sign if information is true, complete and correct.

8. Our Privacy Statement

You can view our Privacy Statement on our website: www.discovery.co.za/corporate/privacy.