

MEDICASH Application Form

Name of Agent/Broker _____

Agent / Broker code _____

Medical aid (if applicable) _____

Personal Details

Title Dr Mr. Mrs. Miss Other Specify _

Surname: _____

First name: _____

Identity number : _____

Date of birth: _____

Postal address: _____

Residential address _____

Home Tel No: _____ Work Tel No: _____

Cell No; _____ Fax No: _____

E-mail: _____

Do you require more than one **MEDICASH** card?

(up to 5 cards per family) _____

I hereby authorize you to issue an additional card to : _____

Surname: _____

First name _____

Identity number _____ Signature (of Secondary cardholder) _____

Employment Details

Name of employer: _____

Business address: _____

Telephone no: _____

Fax number: _____

Your Payment Instructions

I hereby authorize Medicash to debit my account, details as given below,

With a fixed payment of R _____ on the _____

Day of every month(specify a day) _____

Corporate Funding

Company Name: _____

Your Account Details to be debited

Bank: _____ Branch: _____

Branch Code: _____ Account number: _____

Account type (Mark with an X) _____

Current		
Savings		
Transmission		

I have read the Terms and Conditions of use of my Medicash card overleaf and agree to be bound thereby. An exact copy of the Terms and Conditions will be enclosed with my card and sent to me. I agree that the Medicash card and sent to me. I agree that the Medicash card will be used for expenses of a medical nature only

Signature: _____ Date : _____

Post to Po box 5511, Rivonia 2128 Fax to (011) 781 8540