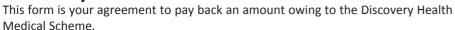
Settlement agreement for an amount owing to the Discovery Health Medical Scheme





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-	ntact	116
LU	IILALL	us

Tel: 0860 99 88 77, PO Box 784262, Sandton 2146, www.discovery.co.za

What you must do

Please fill in the form, sign it and send it back to us.

How to complete this application form

- Please use one letter per block, complete with black ink and print clearly.
- To avoid administrative delays, please make sure this form is completed in full.

Once complete, please fax your form to 011 539 7232 or email it to healthinfo@discovery.co.za																												
1. Main membe	r's details and	acknow	ledgen	nent o	of ar	noui	nt o	win	g																			
Member name(s) (a	s per identity document)																											
Member surname																												
Membership numb	er															[Date	of	birt	h	Υ	Υ	Υ	Υ	M	M	D	D
ID number										F	Pass	oort	nuı	mb	er													
Telephone (H)														(V	/) [
Cellphone														Fa	x [
Email address																												
By signing this form you acknowledge and agree to settle any amount owing to the Scheme. You acknowledge that the amount quoted can change and is based on the information we have at the time. Where the amount we quote is different to the final amount that is due, you agree to pay back the full amount. Note: if the amount you owe the Scheme changes, we will contact you and offer you new payment terms. Signature of main member							e:e																					
2. Method of pa	ayment																											
Please choose your Direct debit [Direct deposit [method of payn (please con		ction 3)																									
Amount owing R																												
If you choose to pa	y the outstandin	g amount	by dire	ect de	posit	, plea	ise u	ıse t	he fo	llow	ing	ban	k ac	cou	unt:	:												
Bank	FNB																											
Branch	JHB Corporate																											
Branch code	255005																											
Account type	Current																											
Account number 58861132934																												
Please use your Discovery Health membership number as the reference when making direct deposits and fax the proof of payment to us.																												
3. Your banking details if you are paying by direct debit																												
Name of accountho	older																											
Account number										Ty	ype (of a	ccou	unt		(Che	que	:	Т	ran	smi	ssic	n [Sav	ing	s 🗌
Bank name																												

n time for the debit order date you have chosen above, the debit order will be submitted in the following month on the same day you specified or following working day.

Branch number

To be debited on*

Branch name

Full amount owing

3. Your banking details if you are paying by d	irect debit (continued)	
The amount that we quote as owing to the Scheme of	very Health Medical Scheme to deduct the agreed amount from the scan change because of late or outstanding claims the Scheme mount to the outstanding amount we quoted you and that you	receives and pays. By signing
Signature of accountholder		
Signed at (town or city)		on
2 0 Y Y M M D D		
Signature of main member		