TopMed Medical Scheme
PO Box 1462, Durban, 4000
Client Services: 0860 00 21 58
Website: www.topmed.co.za

GROUP CONTRACT

A DETAILS OF THE EMPLOYER

Please note: It is extremely important that the Employer be fully and properly described. Every question must be completed by the Employer and, if the question is not applicable, insert N/A.

If Employer is a company or Close Corporation state:

Full Registered Name

Registration Number

If above is not applicable, please state if partnership/sole proprietor, pensioner or other:

Name or Trading Name

Type of Business

Physical Address

Postal Code

Postal Address

PostalCode

Telephone Number

Fax Number

Name or Trading Name

Email Address

Contact Person

Has the Employer/Member previously belonged to TopMed? Yes ☐ No ☐

If your answer is 'Yes', please state the previous Group/Membership Number:

Present Medical Scheme

Group Number

Expected Termination Date D D M M Y Y Y Y

Banking Details

Name of Account Holder

Name of Bank

Branch Name

Branch Code

Account Number

Account Type Current ☐ Savings ☐ Transmission ☐

Please Note: This Contract must be accompanied by a completed ACB instruction form.

B EMPLOYEE AND PENSIONER DETAILS

Total number of Employees (including working Directors, Partners, etc)

Total number of Employees requiring medical aid cover

Total number of Pensioners requiring medical aid cover

Initial here

C OPTIONS TO BE MADE AVAILABLE TO MEMBERS

Please indicate with an 'X' the option required

TopMed Rainbow Comprehensive	
TopMed Professional	
TopMed Paladin Comprehensive	
TopMed Savings	
TopMed Active Saver	
TopMed Hospital	
TopMed Limited	

TopMed Network (please tick your salary band below)

Salary Band	< R1 000	
	R1 001 - R4 000	
	R4 001 - R7 000	
	R7 001 - R13 000	
	> R13 000	

Please provide your latest 3 months' bank statements or the following supporting documents as proof of income for you and your spouse/partner:

- If employed - payslip or most recent tax year's IRP5 certificate
- If student, formal proof of enrolment at academic institution (student cards are not considered as proof).
- If individual - income for both member and spouse
- If pensioner - proof of annuity and employer pension or State Older Person's Grant

D ONLINE DATA ACCESS

Would you like access to your information on the TopMed website? Yes ☐ No ☐

Email Address

Preferred User Name

E ELIGIBILITY

Please Note: This section should be completed with the assistance of a suitably qualified Member of TopMed's staff as it is essential that eligibility be fixed and that there be no doubt as to which Employees are regarded as being eligible Employees.

All eligible Employees are bound to apply for Membership to TopMed, as are eligible new Employees joining the Employer in the future. Selection is not permitted and, in the event of non-compliance, the Employer shall cause all Employees who are Members to forthwith resign their membership of TopMed. Eligible employees currently subscribe to the following medical schemes:

1)

2)

3)

We hereby confirm that their membership has been/will be terminated effective D D M M Y Y Y Y with a view to joining TopMed.

The Employer hereby declares the following categories of Employees to be eligible as aforesaid:

Employees earning not less than R

Administrative Employees

Executive Employees

Salaried Employees

Other (please specify)

F DATE OF COMMENCEMENT

The Employer shall commence on the first day of Y Y Y Y.

All Employees shall apply for Membership of TopMed with effect from the date of commencement and, where such Employees are accepted as Members, their Inception Date shall be the abovementioned date of commencement.

G DETAILS OF INTERMEDIARY

Brokerage Name

Brokerage Code

Telephone Number

Broker Name

Broker Sub Code

Signature

Date D D - M M - 2 0 Y Y

Initial here

H THE RULES

1. The Rules of TopMed as amended from time to time shall bind TopMed, the Employer and the Members.
2. The person signing the Contract on behalf of or as the Employer acknowledges that he has been given a set of Rules and that he has read them prior to signing this Contract.
3. Subject to the provisions of the Scheme Rules, all Employees shall become Members.
4. The Employer shall submit application forms in respect of all eligible Employees and prospective Dependant's.
5. If the Employer does not pay the Contributions and any other amounts due to TopMed in respect of the Member's Group, the Membership of such Member's will be terminated.
6. The Scheme will send invoices monthly to the Employer for Contributions due by the Group and other amounts due to TopMed.
7. The Employer shall pay the amount due under such invoices in such a way as to reach TopMed's offices by no later than the fourth day of the month in which they were due in.
8. If required by TopMed, the Employer shall make payment of Contributions and other amounts due to the Scheme by ACB, stop order or any form of electronic bank transfer which TopMed may reasonably require.
9. TopMed is not obliged to pay any Benefits where the Member is in breach of any of the Member's obligations in terms of the Rules and in particular where any Contribution or part thereof is in arrears.
10. The Employer is the agent of the Member and not of TopMed in dealings between an Employee and TopMed.
11. The Employer must notify TopMed within 30 days of any change of address and failure to notify will absolve TopMed from any liability should the Employer or Member's rights be prejudiced or forfeited.

I FURTHER TERMS

1. The Employer warrants that the Employer has an arrangement in place, with every Member of the Group, that amounts due to TopMed shall be recouped by the Employer from such Member's income.
2. The Employer shall only be entitled to terminate the Group's Membership of TopMed consequent upon three calendar month's written notice of termination having been given to TopMed.
3. Notwithstanding anything to the contrary contained in the Rules, where the Employer gives late notification to TopMed of the termination of the Contract of Employment of any Employee, the Employer shall be liable to pay contributions and other amounts due to the Scheme payable in respect of such Employee up to the end of the month during which TopMed receives notification that such employment has terminated.
4. The Company shall deduct all amount due to TopMed from the remuneration due to the Employee and shall be responsible for ensuring that the same is done in compliance with law. Likewise, the Company shall be responsible for arranging with the Company's pension and other schemes that all sums due to TopMed by the Employee upon the Employee's ceasing to be employed shall be paid by such pension or other scheme, direct to TopMed, particularly where the Employee ceases to be a Member of TopMed, the company shall pay all amounts due by the Employee to TopMed including but not necessarily limited to Contributions, amounts paid to Providers and amounts lent and advanced by TopMed to the Employee to assist the Employee in paying for Relevant Health Services.
5. Where the Group's Membership of TopMed is terminated, the Employer shall ensure that the Membership of all Pensioners is also terminated, notwithstanding that such Pensioners are no longer Employees of the Employer and will be responsible for any loss or damage (particulary any underwriting loss) which the Scheme may suffer as a consequence of such Pensioners continuing as Members of TopMed.

J ONLINE ACCESS

1. I accept that TopMed will not in any way be responsible or liable for any claims of any nature whatsoever made by anyone (myself included) which give as a result of my failing to keep my password and user name secure and confidential to myself.
2. I indemnify TopMed and hold it harmless against any such claims.
3. I understand that this service may not be available 24 hours a day.

Dated at _____ this _____ day of _____ 2 0 Y Y

As witnesses:

1. _____

2. _____

Company Stamp

For and on behalf of the Employer and warranting that I am duly authorised to bind the Employer

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DEBIT / CREDIT ORDER INSTRUCTION

Member Name

Member/Group Number ID Number

Telephone Number

Postal Address

Postal Code

TO WHOM IT MAY CONCERN

Debit ☐ Credit ☐

The details of my/our bank account is/are as follows:

Name of Account Holder

Name of Bank

Branch Name Branch Code

Account Number

Account Type Current ☐ Savings ☐ Transmission ☐

PLEASE NOTE THAT CREDIT CARD TRANSACTIONS ARE NOT ALLOWED AGAINST YOUR MEDICAL AID CONTRIBUTIONS AND REFUNDS.

I/We hereby instruct and authorise you to debit/credit amounts which may be due to/by me/us to the debit/credit of my/our account with the abovementioned bank, or any other bank to which I/we may transfer my/our account.

I/We understand that the debit/credit transfers hereby authorised will be processed by computer through a system known as ACB Magnetic Tape Service and I/we also understand that no advice of the debit/credit will be provided by my/our bank, but details of each debit/credit will be printed on my/our statement or on any accompanying voucher.

I/We agree to pay any bank charges relating to the debit order instruction.

I/We understand that Billing advices and details will be supplied in the normal way and that the debit/credit will be actioned at least ten days after the date of Statement to/from my/our account.

This authority may be cancelled by me/us by giving thirty days written notice, sent by prepaid registered post, but I/we understand that I/we shall not be entitled to any refund amounts which have been withdrawn while this authority was in force if such amounts were legally owing by me/us.

SIGNATURE OF ACCOUNT HOLDER (MANDATORY) _____ DATE D D M M Y Y Y Y

SIGNATURE OF PRINCIPAL MEMBER (MANDATORY) _____ DATE D D M M Y Y Y Y

SIGNATURE OF GROUP / EMPLOYER (WHERE APPLICABLE) _____ DATE D D M M Y Y Y Y

SIGNATURE OF BROKER / INTERMEDIARY (WHERE APPLICABLE) _____ DATE D D M M Y Y Y Y

PLEASE NOTE: Changes to your banking details will only be processed upon receipt of a valid copy of your identity document attached to this application.

You will receive your Billing statement and details as usual and the debit order will be actioned at least ten days after the date of statement. If for some reason you do not agree with the statement and do not want the Debit Order actioned, kindly telephone us on **0860 00 21 58** so that alternate arrangements can be made.

GROUP STAMP