



Contact details

Tel: 0860 101 252 • PO Box 652509, Benmore 2010 • www.retailmedicalscheme.co.za

Settlement agreement for an amount owing to Retail Medical Scheme

This form is your agreement to pay back an amount owing to Retail Medical Scheme.

Who we are

Retail Medical Scheme (referred to as “the Scheme”), registration number 1176, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as ‘the Administrator’) is a separate company and an authorised financial services provider (registration number 1997/013480/07). Discovery Health (Pty) Ltd administers Retail Medical Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly. Alternatively, complete the form digitally.
2. To avoid administration delays, please ensure this application is completed in full.
3. Once complete, please email your form to service@retailmedicalscheme.co.za.

1. Main member’s details and acknowledgement of amount owing

Member's name/s (as per identity document)																							
Member surname																							
Membership number													Date of birth	Y	Y	Y	Y	M	M	D	D		
Staff number																							
ID or passport number																							
Telephone (H)													Telephone (W)										
Cellphone																							
Personal 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

2. Method of payment

Please choose your method of payment:

Direct debit (please complete section 3) Direct deposit Employer deduction

Amount owing R

Payroll

Monthly deduction R

If you choose to pay the outstanding amount by direct deposit, please use the following bank account:

Bank	FNB
Branch	JHB Corporate
Branch code	255005
Account type	Current
Account number	62050332601

Please use your Retail Medical Scheme membership number as the reference when making direct deposits, and email the proof of payment to us.

3. Your banking details if you are paying by direct debit

Name of account holder	<input type="text"/>															
Bank name	<input type="text"/>															
Branch name	<input type="text"/>			Branch number	<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>							
Account number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Type of account	Cheque <input type="checkbox"/>	Transmission <input type="checkbox"/>	Savings <input type="checkbox"/>								
Full amount owing	R	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Date <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

By signing this direct debit request, I authorise the Retail Medical Scheme to deduct the agreed amount from my bank account.

Signed at (town or city) Date

Signature of account holder

Signature of main member