GOLDEN ARROW
EMPLOYEES' MEDICAL BENEFIT FUND

BANKING DETAILS FORM

This form is used to collect or update banking information for payment or debit purposes.
Please complete all sections clearly and accurately.

MEMBER INFORMATION

Full Name: _____ Membership Number: _____

ID/passport number: _____ Contact Number: _____

Email address: _____

BANKING DETAILS

(Do not submit credit card information. The Scheme Administrator is not authorised to collect or retain such details.)

Account Holder Name: _____ Bank Name: _____

Branch Code: _____ Account Number: _____

Account Type: Current/Cheque ☐ Savings ☐ Transmission ☐

Specify your choices by ticking the relevant boxes.

☐ I hereby instruct and authorise the Scheme and it's Administrators to debit my account for **MEDICAL CONTRIBUTIONS.**

☐ I hereby instruct and authorise the Scheme and it's Administrators to use this account for all **CLAIM REFUNDS.**

Please attach the following supporting documents:

- Copy of the account holder's ID
- Proof of banking details (e.g., bank statement or confirmation letter with stamp)

Please submit the completed form and supporting documents to: **membership@goldenarrowmed.co.za**

- I hereby confirm that the above banking details are correct.
- I hereby authorise the Scheme and it's Administrators to use this information for the purpose of processing payments or debits as indicated.
- I understand that this authority may be cancelled by me/us by giving 30 days written notice.
- I understand that the Scheme and it's Administrators will not be held responsible if notification of change in banking details is not provided in the above specified time.
- I understand that the Scheme or Administrator will not accept liability for any payment made into the incorrect bank account.
- If the account is held in the name of another individual, the account holder must sign below to grant permission for deductions and provide a copy of their ID.

Member signature _____

Date _____

Account holder's signature _____

Date _____

12/2025

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