AECI Medical Aid Society
PO Box 800
Florida Hills
1716
Tel: **0860 00 2103**
Email: **aecisociety@medscheme.co.za**

MEMBER APPLICATION: ELECTRONIC TRANSFER OF FUNDS

PLEASE COMPLETE DIGITALLY

Email your completed form to **aecisocietymembership@medscheme.co.za**

SECTION A | TO BE COMPLETED BY THE PRINCIPAL MEMBER OF THE SCHEME

Name:	
Surname:	
ID Number:	
Membership Number:	
Tel No. (H):	
Tel No. (W):	
Cell:	
Email Address:	
Postal Address:	
Residential Address:	

SECTION B | TO BE COMPLETED BY ACCOUNT HOLDER

Mark relevant box with an X	Principal Member:		Company:	
Select Account Holder:	Trust:		*Individual other than Principal Member (For example spouse, parent, child, etc):*	

Title:	
First Name:	
Initial(s):	
Surname:	
Date of Birth:	
ID Number:	
Passport Number: *(For non-SA Citizens)*	
Country of Issue:	
Tax Number (SARS):	
Registered Company Name: *(If the account is in the name of a company)*	
Company Registration Number:	
Residential Address:	
Postal Code:	
Postal Address	
Postal Code:	

Mark relevant box with an X		**Contributions only**	
Use this account for:		**Contributions and Claim refunds**	

Bank Name:		Branch Name:					
Branch Code:		Type of account: *(Mark with an X)*		Current		Transmission		Savings
Account Number:							
Account Holder:							

Mark relevant box with an X		
Use this account for:		**Refunds Only**

Bank Name:		Branch Name:					
Branch Code:		Type of account: *(Mark with an X)*		Current		Transmission		Savings
Account Number:							
Account Holder:							

SECTION C – REQUIRED DOCUMENTS

In order to change you bank details, please provide the below documents for verification purpose:

- Copy of the account holder's ID or copy of passport for non-SA citizens
- Copy of stamped bank statement (not older than 3 months) or stamped confirmation letter from the bank in the name of the account holder

Account in the name of an individual other than the Principal Member (for example spouse, parent child, etc)

- ID Copy of the Principal Member or copy of passport for non-SA citizens
- ID Copy of the account holder or copy of passport for non-SA citizens
- Copy of stamped bank statement (not older than 3 months) or stamped confirmation letter from the bank in the name of the account holder
- Signed letter of authority from the account holder which include the details of the member(s)

Account in the name of a company

- Copy of stamped bank statement (not older than 3 months) or stamped confirmation letter from the bank in the name of the Company
- Signed letter of authority on a company letterhead including the details of the member(s)
- ID copies of each signatory who has authority to sign on behalf of the company
- Copy of Company Registration Certificate

Trust Account

- Copy of stamped bank statement (not older than 3 months) or stamped confirmation letter from the bank in the name of the Trust
- Signed letter of authority including the details of the member(s)
- ID Copies of each trustee
- Copy of Trust resolution showing the trustees

SECTION D | DECLARATION

I, ______________________ *(account holder's full name) the undersigned, declare that:*

☐ I understand that Medscheme/AECI Medical Aid Society will rely upon the facts set out herein for the accurate loading of bank details. I understand and accept that should any details contained herein prove to be incorrect, or should I fail to inform Medscheme/AECI Medical Aid Society of any subsequent change to the bank details, Medscheme/AECI Medical Aid Society will not be held responsible. I also agree that I am the account holder of the bank details provided and I hereby authorise Medscheme/AECI Medical Aid Society to electronically collect monthly contributions and/or pay refunds to the above bank via Electropay system using informaton provided. I also irrevocably authorise Medscheme/AECI Medical Aid Society to reverse any erroneous transaction and/or rectify any electronic transfer of funds error without prior notice.

☐ I hereby authorise Medscheme/AECI Medical Aid Society, or any of its nominated representatives, to verify the bank details as stipulated on this form.

☐ Give consent that Medscheme/AECI Medical Aid Society, may collect, process, store and share our personal information with the Scheme's respective Service Providers including South African Revenue Services. This information includes, but is not limited to details such as name, surname, or registered name (in cases of companies and trusts), identity numbers, registratoin number, tax number, addresses and other details which could include financial information and banking details

Principal Member Signature:		Date:	
Account Holder Signature		Date:	

07/2026