The Building & Construction Industry Medical Aid Fund

Reference no. 1590. Registered in terms of the Medical Schemes Act no. 131 of 1998

EST 1964
BCIMA
Medical Aid

Continuation, Employer and Administrative Staff Members Information Update Form

PRINCIPAL MEMBER DETAILS

Kindly complete and fax, post or email: bcimafund@universal.co.za

Membership no.: | | | | | | | | Date of Birth: D D M M Y Y Y Y

Surname & Initials:

Title: Marital Status: Nationality: Present Age:

ID no.: | | | | | | | | | | | | | |

Race: African | Coloured | Indian/Asian | White

Tax Reference no.:

Postal address:

Code:

Physical address:

Code:

Tel no.: Home: ( ) Work: ( )

Cell: ( ) Fax: ( )

E-mail:

Please ensure your contact details are updated at all times.

Occupation: Date Employed:

Written proof of all income must be attached to this form. i.e. pension, gross monthly income, commission, dividends, fringe benefits, interest, etc. (Latest IT34 tax assessment and certificates)

(Self) R	(Spouse) R

J C C I House, 27 Owl Street, Cnr Empire Road, Milpark / P.O. Box 3201, Johannesburg 2000
Email: bcimafund@universal.co.za / **Tel:** 011 208 1005 / **Fax:** 086 726 6633 / **Website:** www.bcima.co.za

Universal™

Administered by Universal Healthcare Administrators (Pty) Ltd

BANKING DETAILS

Name of account holder:

Bank:

Branch name: Branch code:

Account no.:

Account type: Cheque/Current Savings Transmission

PLEASE REMEMBER TO ATTACH PROOF OF BANK DETAILS WHEN SUBMITTING THIS FORM. CONFIRMATION LETTER FROM THE BANK OR BANK STATEMENT.

Authorised signature

Date: D D M M Y Y Y Y

DISCLAIMER: It is the member's responsibility to advise the administrator in writing of any change in banking details. Neither the Fund nor its Administrators will be held liable should an incorrect amount be credited under any circumstances.

BCIMA Claims Dept. Date: D D M M Y Y Y Y

The Fund shall take all reasonable steps to ensure that all staff within the Fund and all third parties who have access to beneficiary information for the purpose of data transfer and management, Fund Administration, Managed Care agreements and compliance with applicable legislation, keep the personal information of beneficiaries confidential and comply with applicable legislation.

EMPLOYER DETAILS

Name of Employer: Registration No:

Contact person:

Postal Address:

Code:

E-Mail Address:

Tel no.: ( ) Fax: ( )

Cell: ( )

I declare that I have disclosed all particulars relevant to this update form and that I am aware that any false statement or non-disclosure of information will relieve the Fund from liability and subject my membership to cancellation.

SIGNATURE OF APPLICANT

Date: D D M M Y Y Y Y

EMPLOYERS SIGNATURE AND/OR COMPANY STAMP

Date: D D M M Y Y Y Y

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