

## UMVUZO HEALTH EMPLOYER AGREEMENT

### SECTION A: EMPLOYER DETAILS

Name of Employer/Company			
Registration number			
Business address (Employer)			
			Code
Postal address (Employer)			
			Code
Tel number (contact person)			
Email address (contact person)			
Employer contact person			
Nature of business			

### SECTION B: GROUP DETAILS

Inception date/s	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	to	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Total number of permanent staff employed by your company															
Total/estimated number of principal members to be covered under Umvuzo															

#### Member's correspondence should be sent to (tick one):

Company's postal address	<input type="checkbox"/>	Member's postal address	<input type="checkbox"/>
If Company, add address			
			Code

### SECTION C: DETAILS FOR MONTHLY BILLING

Contact person for monthly billing				
Telephone number				
Email address				
Monthly billing	Advance	<input type="checkbox"/>	Arrears	<input type="checkbox"/>
Day of month statement required/Date billing is required				

#### Breakdown of billing

One statement for the entire group	<input type="checkbox"/>	A statement per branch	<input type="checkbox"/>
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## Contact details per branch

1.	Contact name	
	Telephone number	
	Email address	
	Branch name	
2.	Contact name	
	Telephone number	
	Email address	
	Branch name	
3.	Contact name	
	Telephone number	
	Email address	
	Branch name	

## SECTION D: PAYMENT DETAILS

Monthly contributions must be paid through electronic funds transfer (EFT), by using the banking details below.

Account holder name	UMVUZO HEALTH MEDICAL SCHEME	Branch	63-20-05
Account type	GROWBUS	Swift Code	ABSA ZA JJ
Account number	40-6002-6507		
Branch ABSA	MENLYN MAINE		

## SECTION E: TERMS AND CONDITIONS

- We hereby apply for Umvuzo Health membership for our employees.
- We warrant the correctness of all information in this application and of all other documents submitted now or in the future by any officer on behalf of the employer.
- We acknowledge that Umvuzo Health reserves the right to suspend/cancel membership if any contribution is not paid on the due date.
- We acknowledge that Umvuzo Health will assume no liability for any employee until such time as Umvuzo Health gives notice of acceptance of the risk.
- We undertake to immediately give Umvuzo Health notice in writing should any changes material to the assessment of this application occur before the date upon which Umvuzo Health grants written acceptance. This will enable Umvuzo Health to consider the terms of acceptance.
- We acknowledge being aware of the fact that in terms of the Medical Scheme Act (Act 131 of 1998), contribution must be paid over to the Scheme within 3 days after becoming due at the end of each every month and undertake to deduct monthly contributions from our active employees and pay it over to Umvuzo Health.
- Changes regarding membership of employees, i.e. resignations, addition/withdrawal of dependents shall be sent/forwarded to the Scheme within 7 days after receipt thereof.
- This agreement may be terminated by giving the Scheme at least 3 calendar months written notice.
- Individual member applications: Please note that a fully completed form is required for each applying principal member.

## SECTION F: DETAILS OF INTERMEDIARY

Broker house	
Broker code/reference number	
Broker name (individual)	
Full first name	
Surname	

# UMVUZO HEALTH EMPLOYER AGREEMENT

Telephone number

Cell number

Email address

\_\_\_\_\_  
Signature of intermediary

Date

\_\_\_\_\_  
Signature of employer

Date