EFT AUTHORISATION FORM

www.wcmas.co.za
wcmas@wcmas.co.za
C/o Susanna St & OR Tambo Rd
P O Box 26, Emalahleni (Witbank), 1035
Tel: 013 656 1407 Fax: 0866277795

Membership / Practice Number

1. Practice / Principal member details

Practice name / Member first full name and surname		Initials	
Practice contact person :			

Identity number / passport number (only foreigners to insert passport numbers)													Date of birth	

Ethnic Group:	African		Asian		Coloured		Indian		White		Other	

2. Contact Details (Please confirm even if unchanged)

Postal Address	Residential / Practice Address	Cell phone:
		Tel: (H)
		Tel: (W)
		Fax:
(Code)	(Code)	

E-mail address:

3. Banking details

Account holder's name		Account number			**The form must be accompanied by proof of banking details as listed in section 4.9.**
Bank name		Branch name		Branch code	

Type of account	Savings		Cheque		Transmission		Applicable to	Debit order payments		Electronic refunds	

By signing this form, you agree that, once refunds have been paid into the bank account of which the details are provided for above, WCMAS will not be responsible in any way for the amounts refunded

4. Protection of personal information

In accordance with the Protection of Personal Information Act No 4 of 2013 (hereafter referred to as the PoPI Act) please take note of the following:

4.1 WCMAS and its representatives (e.g., third party administrator, duly authorised representatives of WCMAS, managed care organisation, etc.) will have access to all medical records and personal information of the principal member and his / her dependants, which includes children subject to parental control in terms of the law. WCMAS and said representatives will also be permitted to visit members or dependents (where applicable) at in-patient facilities where the member or dependent may receive treatment and where WCMAS deems this to be in the interest of the patient. WCMAS will keep all such information confidential and will only disclose the personal information to its representatives and other third parties, if required for the assessment and payment of benefits, collection of monies owed by the member or service providers to WCMAS or as otherwise authorised in terms of the law.

4.2 The rights of the member or his / her dependant (i.e. data subject) are detailed in section 5 of the PoPI Act.

4.3 Personal information is defined in the PoPI Act as information relating to an identifiable living, natural person, and where it is applicable, an identifiable, existing juristic person, including, but not limited to:

- Information relating to the race, gender, sex, pregnancy, marital status, national, ethnic or social origin, colour, sexual orientation, age, physical or mental health, well-being, disability, religion, conscience, belief, culture, language and birth of the person;
- Information relating to the education or the medical, financial, criminal or employment history of the person;
- Any identifying number, symbol, e-mail address, physical address, telephone number, location information, online identifier or other particular assignment to the person;
- The biometric information of the person;
- The personal opinions, views or preferences of the person;
- Correspondence sent by the person that is implicitly or explicitly of a private or confidential nature or further correspondence that would reveal the contents of the original correspondence;

- The views or opinions of another individual about the person; and
- The name of the person if it appears with other personal information relating to the person or if the disclosure of the name itself would reveal information about the person.

4.4 WCMAS and its representatives will collect the personal information of the member and his / her dependants directly from the member, his / her dependants, health care providers that have provided health care services to the member and his / her dependants and other relevant sources for the purposes set out below.

4.5 WCMAS will collect, process and retain, amongst others, the personal information of the member and his / her dependants contained in the authorisation form, the documents provided in terms of 4.9 and the claims from service providers as well as benefit payments and clinical information relevant to the authorisation form, claims and benefits.

4.6 The personal information will be collected and processed by WCMAS and its representatives for the purpose of assessment and processing the amendment to information, underwriting, determination of benefit entitlements, provision of medical scheme benefits, assessment of claims, reimbursement of claims, risk management, collection of monies owed to WCMAS, compliance with the Medical Schemes Act and the registered rules of WCMAS and any related matters.

4.7 The member undertakes to update his / her personal information as soon as reasonably practicable after changes have occurred. This will ensure that the records of WCMAS contain information that is accurate and up to date.

4.8 The personal information of the member and his / her dependants will be retained as part of the records of WCMAS for as long as required by the Medical Schemes Act, the Scheme Rules, the South African Revenue Service, the Protection of Personal Information Act and any other applicable legislation for as long as is necessary in order to provide medical scheme services to the member and his / her dependants and for other lawful, historical, statistical and research purposes.

4.9 The supporting documentation listed below **must** accompany this EFT authorisation, failure of which will result in a rejection of this form by WCMAS (tick the relevant block if the documents referred to are attached to this authorisation form):

☐ Proof of banking details (either a bank stamped statement, a confirmation letter from the bank indicating the banking details or a cancelled cheque none of which should be older than 3 months.)

☐ Copy of ID

4.10 The name and address of the party responsible for safekeeping of the information is detailed as follows:
Witbank Coalfields Medical Aid Scheme
Physical address: 2nd Floor WCMAS Building; C/o Susanna & OR Tambo road; Emalahleni; 1034
Postal address: P O Box 26; Emalahleni, 1035

4.10 Complaints regarding compliance with the PoPI Act can be addressed to WCMAS or the Information Regulator when established.

4.11 Contact details for the Council for Medical Schemes:
Share call number: 086 112 3267
Website: www.medicalschemes.com
Complaints division: complaints@medicalschemes.com

5. Declaration by practice / member (on behalf of all dependants)

I, the undersigned, hereby:

5.1 Confirm that I understand that WCMAS will process personal information (which includes the collection, use and retention of such information) about me and my dependants as set out in section 4 above. I specifically consent on my own behalf as well as on behalf of my dependants (as appropriate) to the processing of such information by WCMAS and its representatives as set out in section 4.

5.2 Confirm that I understand that it is my responsibility to update my information with WCMAS that has changed as soon as reasonably practicable after the change has been effected

5.3 Confirm that I have attached true copies of documentation provided.

5.4 Confirm that I am aware of my right to request changes to my personal information as included in the records of WCMAS in accordance with the PoPI Act.

5.5 Confirm that I have read and understood all the information contained in this EFT authorisation form.

5.6 Declare that all the information provided is true and correct to the best of my knowledge and belief.

5.7 Acknowledge that, in instances where a broker or any other person completed this form on my behalf, I will remain liable for the information disclosed herein.

5.8 Applicable to members only: I hereby authorise my employer to deduct from my salary each month the specified contributions and other debt owed to the Scheme and to pay the money to the Scheme on my behalf as the case may be.

PLEASE EMAIL THIS FORM BACK TO MEMBERSHIP@WCMAS.CO.ZA

__________________________ ____________________
Doctor / Member Signature Date

__________________________ __________________________
Witness Witness

FOR OFFICE USE ONLY

Members:	**Telephone confirmation**		**Practices:**	**BHF file**	
	Call log number:			Check successful:	
	Check successful:			**Telephone confirmation**	
				Call log number:	
				Check successful:	