Settlement agreement for an amount owing to LA Health Medical Scheme

LA Health
Powered by Discovery

Contact details
Tel: 0860 103 933 • PO Box 652509, Benmore 2010 • www.lahealth.co.za

This form is your agreement to pay back an amount owing to LA Health Medical Scheme

Who we are

LA Health Medical Scheme (referred to as 'the Scheme'), registration number 1145, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. To avoid administration delays, please ensure this application is completed in full.
3. Once complete, please fax your form to 011 539 7232 or email it to **service@discovery.co.za**

1. Main member's details and acknowledgement of amount owing

Member's name/s
(as per identity document)

Member surname

Membership number

Date of birth D D M M Y Y Y Y

ID number

Passport number

Telephone (H)

(W)

Cellphone

Fax

Email address

By signing this form, you acknowledge and agree to settle any amount owing to the Scheme. You acknowledge that the amount quoted can change and is based on the information we have at the time. Where the amount we quote is different to the final amount that is due, you agree to pay back the full amount.

Note: If the amount you owe the Scheme changes, we will contact you and offer you new payment terms.

Signature of main member

2. Method of payment

Please choose your method of payment:

Direct debit ☐ (please complete section 3)

Direct deposit ☐

Amount owing **R** .

If you choose to pay the outstanding amount by direct deposit, please use the following bank account:

Bank	FNB
Branch	JHB Corporate
Branch code	255005
Account type	Current
Account number	6207-5102-120

Please use your LA Health membership number as the reference when making direct deposits and fax the proof of payment to us.

3. Your banking details if you are paying by direct debit

Name of account holder

Account number | Type of account | Cheque | Transmission | Savings

Bank name

Branch name | Branch number - -

Full amount owing **R** . | To be debited on D D M M Y Y Y Y

By signing this direct debit request, I authorise LA Health Medical Scheme to deduct the agreed amount from my bank account.

Signature of accountholder

Signed at (town and city) | Date D D M M Y Y Y Y

Signature of main member