Telephone: 011 340 9000
Telefax: 011 782 0270
Email: surgicom@healthman.co.za

Unit 16, Northcliff Office Park
203 Beyers Naude Drive Northcliff, 2115
PO Box 2127, Cresta, Johannesburg, 2118
Registration No. 1997/001593/07

MEMBERSHIP APPLICATION/UPDATE OF DETAILS FOR SURGICOM

Please allow for a maximum of 5-7* working days, from date of receipt, *for your application to be finalised

I, the undersigned _____ hereby apply to take up membership of Surgicom (the Company), the object of which is to negotiate with the funders of health care, managed care organisations, other health care providers and the suppliers of goods and services to the respective members of the Company, with a view to maximising the potential synergistic and rationalisation benefits for each member. I acknowledge that the Articles of Association of the Company are available for my inspection and I agree that the board may use the pharmaceutical/ claims data as a means of enhancing the group.

SIGNED at_____ this _____day_____20____.

SIGNATURE:_____

Please allow for a maximum of 5-7 working days from date of receipt for your application to be finalised.

Membership information, to be completed by the applicant (or each partner in the event of a group practice). The information below is necessary in order to prepare a complete members database. Please complete in full. Retain a copy for your records. The majority of communications is by e-mail and sms notifications.

TITLE		
SURNAME		
FULL NAMES		
POSTAL ADDRESS		
PRACTICE / PHYSICAL ADDRESS		
PRACTICE NAME		
PRACTICE MANAGER	**Name:**	
	Email Address:	
Sponsors require us to indicate the following fields for the purposes of BBBEE certification: ID Number: Gender: Race:	PRACTICE NUMBER (BHF),(PCNS)	HPCSA REGISTRATION NUMBER
VAT REGISTRATION NUMBER	EMAIL ADDRESS	
PRACTICE TELEPHONE NO.	PRACTICE FAX NO.	CELLULAR NO.
MEMBERSHIP TYPE	☐ Qualified Surgeon in Full Time Private Practice: R790/ month (Vat Incl.) ☐ Qualified Surgeon in Public Sector and/or Limited Private Practice: R320/ month (Vat Incl.) ☐ Surgeon in First Year of Private Practice: Free ***(Please indicate the date in which you started private practice:*** _____ ☐ Registrar: Free ☐ Retired: Free	
SUB-SPECIALTY		

Are you a member of the Association of Surgeons of South Africa? Yes ☐ No ☐

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Written Authority and Mandate for Debit Payment Instructions

This signed Authority and Mandate refers to our contract dated _____ ("the Agreement").
I/We hereby authorise you to issue and deliver payment instructions to your Banker for collection against my/our above-mentioned account at my/our above-mentioned Bank (or any other bank or branch to which I/we may transfer my/our account) on condition that the sum of such payment instructions will never exceed my/our obligations as agreed to in the Agreement and commencing on _____ and continuing until this Authority and Mandate is terminated by me/us by giving you notice in writing of not less than 20 ordinary working days, and sent by prepaid registered post or delivered to your address as indicated above.
The individual payment instructions so authorised to be issued must be issued and delivered monthly.
In the event that the payment day falls on a Sunday, or recognised South African public holiday, the payment day will automatically be the very next ordinary business day. Payment Instructions due in December may be debited against my account on _____*NA*_____*(date).*
I/We understand that the withdrawals hereby authorised will be processed through a computerised system provided by the South African Banks. I also understand that details of each withdrawal will be printed on my bank statement. Such must contain a reference number which is your practice number, which must be included in the said payment instruction and if provided to me should enable me to identify the Agreement.
Mandate: I/We acknowledge that all payment instructions issued by you shall be treated by my/our below-mentioned Bank as if the instructions have been issued by me/us personally.
Cancellation: I/We agree that although this Authority and Mandate may be cancelled by me/us, such cancellation will not cancel the Agreement. I/We shall not be entitled to any refund of amounts which you have withdrawn while this Authority was in force, if such amounts were legally owing to you.
Assignment: I/We acknowledge that this Authority may be ceded or assigned to a third party if the Agreement is also ceded or assigned to that third party, but in the absence of such assignment of the Agreement, this Authority and Mandate cannot be assigned to any third party.
You will be notified within 30 days of the next debit order payment of any fee increases for your membership.
Your debit order will then automatically be adjusted to reflect these increases.

Payment to (Company name) Registered abbreviated company name	***SURGICOM***
Name of account holder	
Address of account holder	
Practice number	
Banking details	
Name of Bank	Type of Account
Branch Name	Branch code
Account number	Monthly amount: □R790 □R320

Signed at _____ on this _____day of _____

_____
(Signature as used for operating on the account)

Please attach a cancelled cheque/ proof of banking details. Please ensure you complete the membership application form AND the written authority for debit order payment instructions.
Please fax back to 011 782 0270 or email hillary@healthman.co.za