APPLICANT INFORMATION		
Title:		
First Name (s):	Surname:	
Marital Status:		Sex:
Race (optional):		
Preferred Language:		
Date of birth:	ID:	Telephone (Cell):
Fax:	Email:	Telephone (H):
Residential address:		
Postal Address:		
City:	Province:	Code:

MEDICAL AID INFORMATION:

Name of Medical Aid:	
Health Plan:	
Principal Member:	Other Dependents:
Membership Number:	
Dependent Code:	
Chronic Illnesses/Medication:	
Any Disabilities:	

BANKING DETAILS: DEBIT ORDER

DO YOU CONSENT TO PMCA DEBITING YOUR ACCOUNT EVERY MONTH? YES ☐ OR NO ☐

PLEASE CHOOSE THE DATE YOU WOULD LIKE US TO DEBIT YOUR ACCOUNT?

1ST ☐ 15TH ☐ 25TH ☐ 30TH ☐

Bank Name:	Account Number:	Account Holder:
Branch Name:	Branch Code:	

TERMS & CONDITIONS

Terms & Conditions apply. PMCA refers the applicant to www.medicalaidclaims.co.za for a comprehensive list of all terms and conditions applicable

SIGNATURES

I authorize the verification of the information provided on this form as to my credit and employment. I have received a copy of this application.

Signature of applicant:	Date:
Signature of spouse *(only if for a joint membership):*	Date:

FAMILY ASSIST:

Once off joining fee, immediately payable in the amount of R50.00 and a monthly subscription of R55.00 for PMCA- medical aid assistance.

Signature of applicant:	Date: