



**MEMBER CLAIM SETTLEMENT
ELECTRONIC FUNDS TRANSFER FORM
EB 240**

Please complete the following for health claim settlement by Electronic Funds Transfer (EFT):

Bank Name _____

Branch Name _____

Bank Address _____

Bank Code _____ Branch Code _____

Bank Account # _____ Account Type _____

Account Name _____

E-mail Address _____

Tel. No. (Cell) _____ (W) _____ (H) _____

To ensure speedy and efficient processing, please promptly return to us by fax to **927-4732** or e-mail to **support@medecus.com**.

The above represents my instruction to **Guardian Life Limited** with respect to the settlement of health claims submitted by me for payment through EFT.

Please complete the information below and on reverse side (Page 2)

³Member Name: _____

¹Card No.: _____ ²Member TRN: _____

Company Name: _____

Visit our website at www.medecus.com for information.

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It would be convenient and in my/our interests if Guardian Life Limited (GLL) would remit by way of Electronic Funds Transfer (EFT) any and all monies due and payable to me directly into my/our bank account, details of which are provided above.

In consideration of GLL agreeing to remit payments by EFT to me/us as aforesaid, I/we agree:

1. **THAT** I/we voluntarily and with full knowledge take and assume any and all risk associated therewith;
2. **THAT** GLL shall have no obligation to check or verify authenticity or accuracy of the banking information provided by me/us;
3. **THAT** in acting on the aforesaid banking information GLL shall be deemed to have acted properly and to have fully performed all obligations owed to me/us, notwithstanding that such banking information may have been incorrect, and I/We shall be bound by any banking information on which GLL may act if GLL has in good faith acted in the belief that such banking information is correct;
4. **THAT** GLL may, in its absolute discretion, decline to act on or in accordance with the whole or any part of the aforesaid banking information pending further enquiry to or further confirmation (whether written or otherwise) by me/us, so however that GLL shall not be under any obligation to so decline in any case, and GLL shall in no event or circumstances be liable in any respect for not so declining; and
5. **TO** release GLL from and indemnify GLL against all claims, losses, damages, costs and expenses howsoever arising in consequence of, or in any way related to GLL having acted in accordance with the whole or any part of any banking information or having exercised (or failed to exercise) the discretion conferred upon GLL in Clause 4 above.

Dated this day of, 20 _____

Signed by the accountholder(s) with authority to operate the relevant account(s), or (if a company or other corporate body) signed by its duly authorized officer(s) for and on behalf of

..... Name of Accountholder or Authorized Officer

..... Signature of Accountholder or Authorized Officer

..... (Name of company or other corporate body, if applicable)

..... Name of Accountholder or Authorized Officer

..... Signature of Accountholder or Authorized Officer

For Official Use Only: Index by Member/Card#, TRN and Member Name



**SALARY DEDUCTION AUTHORISATION FORM
FOR HEALTH INSURANCE PREMIUMS TO
PRIVATE SECURITY REGULATION AUTHORITY (PSRA)**

(Please complete using BLOCK CAPITALS)

CONTRIBUTOR'S DATA:

LAST NAME: _____ FIRST NAME: _____ MI: _____

TRN: _____

SELF EMPLOYED: YES NO

COMPANY: _____

COMPANY'S ADDRESS: _____

CONTRIBUTOR'S DECLARATION:

I hereby authorise _____ to deduct fortnightly/monthly/quarterly the amount stated below from my salary and remit to PSRA for submission to Guardian Life Limited, 12 Trafalgar Road, Kingston 5 on a quarterly basis.

Start date of Deductions	(dd/mm/yyyy)
Amount per Fortnight/Month/Quarter	\$

Contributor's Signature: _____ Date: _____