HEALTH PROFESSIONALS GROUP
Your Needs, Our Responsibility

Block 4, Pony Street, Tijger Vallei Office Park
Silverlakes Road, Pretoria, 0084
+27 (0)12 809 1131 +27 (0)12 809 1204
info@healthprofessionalsgroup.co.za
www.healthprofessionalsgroup.co.za

Application: HPG Legal Responder Package

PERSONAL DETAILS:

Title: _____ Full Names: _____

Surname: _____

ID number: _____

Passport Number: _____

Residential Address:

_____

_____

_____ Postal Code: _____

Postal Address:

_____

_____

_____ Postal Code: _____

APPLICANT'S CONTACT DETAILS:

Tel: (w) _____ (h) _____

Mobile Number: _____

Email address: _____

EMPLOYMENT/PRACTICE DETAILS:

Employer/Company Name: _____

Area of Specialization: _____

Practitioner number: _____

Practice address: _____

PAYMENT DECLARATION:

R250.00 PER MONTH MEMBERSHIP FEE

I, _____ THE UNDERSIGNED HEREBY AUTHORISE AND MANDATE HPG TO DEDUCT MONTHLY WITH EFFECT FROM _____ 20_____ THE PREMIUM OF R_____, FROM MY BANK ACCOUNT, IN TERMS OF THIS INSTRUCTION USING FULCRUM AND TRACKING FOR HOWEVER MANY DAYS AND TO REMIT TO CONSTANTIA INSURANCE COMPANY LIMITED UNTIL SUCH TIME AS I CANCEL THIS AUTHORISATION IN WRITING, OR UNTIL SUCH TIME AS I SUBSTITUTE IT WITH A NEW AUTHORISATION. SHOULD MY MONTHLY DEDUCTION DATE SELECTED FALL ON A PUBLIC HOLIDAY OR WEEKEND, I AUTHORISE LEGAL DEFENDER TO DEBIT MY ACCOUNT ON THE PREVIOUS WORKING DAY. SHOULD THE RELEVANT TOTAL PREMIUM BE ADJUSTED BY HPG AS A GENERAL INCREASE OR SHOULD I REQUEST HPG TO UPGRADE OR DOWNGRADE MY POLICY SELECTION WHICH AFFECTS THE PREMIUM PAYABLE, I CONFIRM THAT THE ADJUSTED PREMIUM MAY BE DEDUCTED FROM MY ACCOUNT MONTHLY UNTIL SUCH TIME AS I CANCEL THIS AUTHORISATION. FURTHERMORE, I AUTHORISE HPG TO PERFORM THE NECESSARY VERIFICATION, VALIDATION AND CORRECTION OF THE DEBIT ORDER DETAILS, SUPPLIED BY ME, WITH MY BANK OR OTHER THIRD PARTIES TO ENSURE THAT THE APPLICATION FORM CAN BE PROCESSED.

BANKING DETAILS

ACCOUNT HOLDER NAME: _____

BANK NAME: _____

ACCOUNT NUMBER: _____

BRANCH CODE: _____

TYPE OF ACCOUNT: CHEQUE ☐ **SAVINGS** ☐ **TRANSMISSION** ☐

DATE OF DEDUCTION: ☐ **1ST** ☐ **15TH**

_____ _____

SIGNATURE OF ACCOUNT HOLDER **DATE**

DECLARATION:

I, _____HEREBY DECLARE THAT:

- **TO THE BEST OF MY KNOWLEDGE THE INFORMATION ABOVE IS TRUE AND CORRECT;**
- **THE APPLICATION HAS BEEN COMPLETED IN FULL AT THE TIME OF SIGNATURE AND THE SIGNATURE THAT APPEARS ON THIS DOCUMENT IS MINE;**
- **I HAVE MADE AN INFORMED DECISION AFTER FULLY UNDERSTANDING THE BENEFITS OFFERED, TO SIGN UP FOR THIS MEMBERSHIP VOLUNTARILY;**
- **I ACKNOWLEDGE THAT ALL THE BENEFITS ARE SUBJECT TO THE TERMS AND CONDITIONS OF THE SPECIFIC PRODUCT GUIDE AND INCLUDING ANY ALTERATIONS OR AMENDMENTS THERETO THAT MIGHT BE MADE FROM TIME TO TIME;**
- **I ACCEPT THAT I WILL NOT QUALIFY FOR ANY BENEFIT CONTAINED HEREIN SHOULD MY MONTHLY FEE NOT BE PAID UP TO DATE.**

I, _____AGREE THAT THE INFORMATION CONTAINED IN THIS APPLICATION FORM FOR MEMBERSHIP SHALL FORM PART OF THE BASIS OF THE CONTRACT OF MEMBERSHIP.

I, _____HEREBY GIVE HPG, ABACON, NATMED MEDICAL DEFENCE, MC DE VILLIERS AND NORTON ROSE FULBRIGHT PERMISSION TO ACCESS MY PERSONAL INFORMATION FROM WHICH EVER SOURCE WHICH IS NECESSARY FOR THE SUCCESSFUL RENDERING OF SERVICES CONTEMPLATED IN MY MEMBERSHIP WITH HPG.

SIGNED AT _____ON THIS __ DAY OF _____ 2019

_____

MEMBER

NAME: _____