



RENEWAL FORM – ACCREDITATION OF AN ORGANISATION

ORG Accreditation No:	FSB License No:								
Current Information	Changes: for completion by applicant								
Name of Organisation: _____	Name of Organisation: _____								
Company/CC Reg. No: / /	Company/CC Reg. No: / /								
Postal Address: _____ _____ _____ Code: _____	Postal Address: _____ _____ _____ Code: _____								
Physical Address: _____ _____ _____ Code: _____	Physical Address: _____ _____ _____ Code: _____								
Head of the Organisation:	Compliance officer:								
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;"></td> <td style="width: 30%;">Work: ()</td> </tr> <tr> <td></td> <td>Cell:</td> </tr> </table>		Work: ()		Cell:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;"></td> <td style="width: 30%;">Work: ()</td> </tr> <tr> <td></td> <td>Cell:</td> </tr> </table>		Work: ()		Cell:
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Fax No: ()	Fax No: ()								
E-mail	E-mail								
List medical schemes with which the applicant is contracted with: _____ _____ _____	New/Additional contracts: _____ _____ _____								
As a subcontracted broker: Details of master broker or entity to whom so subcontracted: _____ _____									
List all Brokers representing the applicant: _____ _____									



DECLARATION

1. I declare that, to the best of my knowledge, that the information herein supplied is complete, true and correct and not misleading in any respect.
2. I hereby confirm that I have the necessary authority to furnish this information and to make the undertakings required herein.
3. I undertake to abide by the legislative requirements and by the fit and proper requirements and the code of conduct determined by the Registrar of Financial Services Board in terms of the Financial Advisory and Intermediary Services Act, 2002 from time to time.
4. I undertake to supply any further information requested by the office of the Registrar, or Council for Medical Schemes, as and when required for purposes of carrying out the provisions of the Medical Schemes Act, 1998 and regulations published thereunder.
5. Proof of payment of the prescribed non-refundable application fee of R1000 (Regulation 31 in terms of the Medical Schemes Act, 1998) is attached hereto.

Signature of the duly authorised Applicant

Date

Name (Print): _____ **Capacity:** _____

Banking details:

Bank: ABSA
Vermeulen Street
Account No: 4051 163 394
Branch Code: 517-245
Reference Number:
BR Number

Since all applications/documentation is attended to and filed electronically, this office strongly recommends electronic submission of applications. Renewal forms together with supporting documents can be submitted as follows:

Email:

accredit@medicalschemes.com

Fax: (012) 431 0655

**Physical address: Hadefields Office Block E, 1267 Pretorius Street,
Hatfield, Pretoria**

Postal address: Private Bag X34, Hatfield, 0028