

Settlement agreement for an amount owing to the SAB Medical Aid 2026

Contact details

Tel: 0860 002 133 • www.sabmas.co.za

Who we are

SAB Medical Aid Scheme (referred to as 'the Scheme'), registration number 1209, is a not-for-profit organisation, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the Administrator') is a separate company and an authorised financial services provider and is responsible for the administration of your membership on behalf of the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. To avoid administrative delays, please make sure this form is completed in full.
3. Once complete, email it to collections@sabmas.co.za

By signing this form, you confirm that the information provided is true and correct.

1. Principal member's details and acknowledgement of amount owing

Title		Initials	
Member surname			
Member name(s) (as per identity document)			
ID or passport number		Membership number	
Telephone (H)		Telephone (W)	
Cellphone			
Email address			

By signing this form, you acknowledge and agree to settle the full amount owing to the Scheme. You acknowledge that the amount quoted on the quotation attached is based on the information we have at the time and date of the quotation and if the amount you owe to the Scheme changes after this arrangement was made, we will contact you, either telephonically or in writing and offer you new payment terms.

Signature of principal member

Please do not sign incomplete forms.

2. Method of payment

Please choose your method of payment:

Direct debit ☐ (please complete section 3)

Direct deposit ☐

Amount owing **R**

If you choose to pay the outstanding amount by direct deposit, please use the following bank account:

Bank	FNB
Branch	JHB Corporate
Branch code	255005
Account type	Current
Account number	62699623891

Please use your SAB Medical Aid membership number as the reference when making direct deposits and email the proof of payment to us.

3. Your banking details if you are paying by direct debit

Name of bank																				
Branch name							Branch code		-		-									
Account number							Type of account	Cheque		Savings		Other								
Account holder name																				
Full amount owing	R											To be debited on	D	D	M	M	Y	Y	Y	Y

* If the form is not received in time for the debit order date you have chosen above, the debit order will be submitted in the following month on the same day you specified or the following working day.

By signing this direct debit request, the account holder authorise SAB Medical Aid to deduct the agreed amount from his/her bank account and confirms that:

1. He/she has the right to give SAB Medical Aid the authority to debit such account on a monthly basis. Furthermore, he/she will be liable for any claims, losses or damages of whatsoever nature arising out of debits made by SAB Medical Aid to the account as listed above, should this account have insufficient funds, be incorrect or be held in the name of any other person.
2. He/she authorises SAB Medical Aid to verify the banking details as provided above for the purposes of setting up the required debit order.
3. He/she confirms that the account listed above is active and has not been de-activated due to non-compliance with verification procedures in terms of the Financial Intelligence Centre Act 38 of 2001, as amended ("FICA").

Signature of account holder																					
Signed at (town or city)													on	Y	Y	Y	Y	M	M	D	D
Signature of principal member																					

Please do not sign incomplete forms.