

**Particulars of Business**

Registered Name:		VAT Number:			
Trading Name:		Business Contact Number:			
Email Address:		Fax Number:		Number of Employees:	

Name of Finance Contact:

Contact Number:		Email Address:	
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Name of Payroll Contact:

Contact Number:		Email Address:	
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Name of HR Contact:

Contact Number:		Email Address:	
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Disclaimer

The deduction of premiums from the employee's salary and subsequent payment of the total lump sum to Affinity Health is the responsibility of the Employer. It is important to note that the continuation of services is subject to a monthly premium and your employees will enjoy benefits for as long as the premiums are received. Successful payments will secure cover and services for that month and payment schedules are calculated on a month to month basis. Payment is due by no later than the 7th of each month.

1. I hereby acknowledge and confirm all dependants full premiums will be paid over to Affinity Health and will not be prorated in accordance to hours worked by the employee.
2. The deduction of premiums from the employee's salary and subsequent payment of the total lump sum to Affinity Health is the responsibility of the Employer. It is important to note that the continuation of services is subject to the monthly premium and your employees will enjoy benefits for as long as the premiums are received. Successful payments will secure cover and services for that month and payment schedules are calculated on a month to month basis. Payment is due by no later than the 7th of each month.
3. All dependant amendment forms must be accompanied by an ID copy or birth certificate copy.
4. The full premiums for dependants will be paid over to Affinity Health no later than the 7th of every month
5. The organisation will only be eligible for the 5% admin fee should the full premiums for dependants be paid over to Affinity Health, once full premiums are received, the rebate will be paid back to the organisation.
6. I confirm that the information provided is accurate and that I have the required authority to sign this Form.
7. I further confirm that the company (employer) shall not hold Affinity Health liable for any claims arising from incomplete or inaccurate information provided.

Company Representative Signature:

Date:

**EMAIL ADDRESS FOR GENERAL ENQUIRIES**
info@nbcpshealth.co.za**PLEASE CALL ME**
060 769 8770**WHATSAPP**
083 231 6771**CALL CENTRE**
0861 888 662