

**SECTION 1 - Company information**

Company name \_\_\_\_\_ Program start      DD / MM / CCYY

Company reg. no. \_\_\_\_\_ Company VAT no. \_\_\_\_\_

Postal address \_\_\_\_\_

\_\_\_\_\_ Postal code \_\_\_\_\_

Physical address \_\_\_\_\_

\_\_\_\_\_ Area code \_\_\_\_\_

Employer contacts	First contact person	Back-up contact person
Name	_____	_____
Surname	_____	_____
Designation	_____	_____
Contact number	_____	_____
Cell number	_____	_____
e-mail address	_____	_____

**NB:** The first contact person is responsible for updating employee information. The form overleaf may be utilised for this purpose, or update on-line at [www.libertyhealth.co.za](http://www.libertyhealth.co.za) or send an employee list or electronic payroll file with relevant details to [liberty@cimssa.co.za](mailto:liberty@cimssa.co.za) at any time. . The monthly contribution includes 14% VAT - VAT invoices available on request.

**SECTION 2 - Consultant details**

Name \_\_\_\_\_ Cell number \_\_\_\_\_

Consultant code \_\_\_\_\_ Other phone \_\_\_\_\_

e-mail address \_\_\_\_\_

**SECTION 3 - Bank details and authorisation**

Account number \_\_\_\_\_ Name of Bank \_\_\_\_\_

Account name \_\_\_\_\_ Branch Code \_\_\_\_\_

Debit order on  1<sup>st</sup>  5<sup>th</sup> day of the month Account type savings/transmission/current

**Declaration:** We hereby request and authorise Liberty Health or its appointed agents to draw against our account with the bank mentioned above (or any account to which we may transfer our account) the amounts required in payment of the monthly subscription in respect of the Liberty Health Live Well programme for each of the employees of our company, as notified by us from time to time.

All such withdrawals from our bank account by Liberty Health or its appointed agents will be regarded as authorised by us.

We understand that the withdrawals hereby authorised will be processed by computer through a system known as ACB (Automated Clearing Bureau) and we also understand that details of each withdrawal will be printed on our bank statement or on an accompanying voucher.

This authority may be cancelled by us giving you thirty days notice in writing. We accept that we shall not be entitled to any refund of amounts, which you withdrew while this authority was in force, if such amounts were legally owing to you. Receipt of this instruction by you shall be regarded as receipt hereof by your bank (whichever it is or may be).

We warrant that our employees have authorised us to supply their names and numbers to Liberty Health and their appointed sub-contractors for the purposes of administration and delivery of the benefits of the Live Well programme and that our employees understand that this information will be kept confidential and secure and only for as long as it is needed

Signed at \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_ month \_\_\_\_\_ C C Y Y

Bank account signatory's name(s) \_\_\_\_\_ Designation(s) \_\_\_\_\_

Account holder's signature(s) \_\_\_\_\_

## LIVE WELL EMPLOYEE DETAILS



- Please supply the names and identity numbers of all employees either using this form or on-line at [www.liberty.co.za](http://www.liberty.co.za)
- Attach a scan of this form to an e-mail to [liberty@cimssa.co.za](mailto:liberty@cimssa.co.za) or fax to 086-637-3448.
- Employee detail may also be submitted in the form of an electronic data file or payroll report if preferred.
- Employees will be registered on Live Well immediately and may use the service from the month of the first debit order on the date requested on the application form.

Name and Surname	Identity Number	Name and Surname	Identity Number
1		32	
2		33	
3		34	
4		35	
5		36	
6		37	
7		38	
8		39	
9		40	
10		41	
11		42	
12		43	
13		44	
14		45	
15		46	
16		47	
17		48	
18		49	
19		50	
20		51	
21		52	
22		53	
23		54	
24		55	
25		56	
26		57	
27		58	
28		59	
29		60	
30		61	
31		62	

Completed by (name) \_\_\_\_\_ Date \_\_\_\_\_ D D / M M / C C Y Y

Your position \_\_\_\_\_

e-mail address \_\_\_\_\_

Phone number \_\_\_\_\_ Signature \_\_\_\_\_

**It is the responsibility of the employer to keep employee records up to date by e-mail, website or fax as above**

Please note that in the event of any modification or variation of this standard form Liberty Life will regard this form as being invalid and of no force and effect. **Do not sign blank or incomplete forms.**