1st Floor
Clover Leaf Building
82 Mutare Road Msasa,
Harare, Zimbabwe
Tel: +263 (242) 487 585
+263 (242) 487 713
Mobile: +263 772 341 776
info@investmedhealth.co.zw

SERVICE PROVIDER REGISTRATION AND AMENDMENT FORM

Section 1: Nature of transaction

New registration ☐ **Amendment of details** ☐

Section 2: Service provider Details

AHFOZ Number _____ Member Number _____

Full Name _____

Business Partner Number _____ Tax Clearance Date of Issue _____

Identity Number _____ Date of Birth _____ Gender _____

Contact Person _____ Positon _____

Physical Address _____

Postal Address _____

Cellphone _____ Telephone-Home _____ Telephone-Work _____

Email _____ Start Date _____

Section 3: Banking Details

Please provide your full banking details below for claims payments

Name of Account Holder _____ Bank Name _____

Branch Name _____ Branch Code _____

Account Number _____ Account Type _____

NB: Please provide copies of AHFOZ registration letter, Current TAX Clearance, National ID, Proof of banking details

Declaration Statement

1. I declare that the information contained in this application form is correct in all material terms to the applicant's best knowledge and belief.
2. I am authorised to make this declaration and to provide the relevant information and any supporting documentation that may be required.
3. I declare that in the event of being granted registration as a Service Provider the applicant will comply with Investmed fund rules, policies and regulations.
4. The applicant agrees to notify Investmed Health of all material changes that may arise due to this Service Provision within a reasonable period of time not exceeding 30 days from date of change.
5. The applicant acknowledges and agrees that if no substantial business is placed with Investmed Health within a reasonable time frame, Investmed Health has the discretion to deactivate the applicant as a Service Provider.

Service Provider Representative _____ **Signature**_____ **Date**_____

InvestMed

Health Fund