SERVICE PROVIDER APPLCATION OR AMMENDMENT FORM

Generation Health
P.O. Box 10130
HARARE
Website: www.generationhealth.co.zw

Generation Health
2nd. Floor, Zimnat House
Nelson Mandela Ave./ 3rd. Street
HARARE

***Administered by*:**
Sovereign Health
Tel: (263 4) 793389; 250680
Nelson Mandela Ave./ 3rd. Street
Fax: (263 4) 790700
CDMA : (263 4) 2928629; 2928930

Section A: Nature of transaction: Please tick the appropriate

New registration ☐ Amendment ☐

Section B: Service provider details: *This section must be completed by the service provider contact person*

Title		**Surname**		**Cellphone**	
Name/s				**Identity number**	
Practice name\Surgery				**AHFoZ number**	
Business physical address			**Business postal address** *(if applicable)*		
Telephone (w)			**Fax number**		
Contact person			**Job title**		
Contact person email					

Section C: ZIMRA Tax details

Business name			
Business Partner Number		**Authentication code**	
Tax clearance issue date		**Tax clearance expiry date**	

Section D: Banking details for claim payments

Proof of banking details required in the form of letter from bank or banking details on company letterhead signed and stamped by the relevant issuer

Bank name		**Branch name**		**Branch code**	
Account type		**Account number**			
Account holder (*Company)*					

Declaration statement

1. I am authorised to make this declaration and to provide the information that is contained in this application form and in any supporting documentation;
2. The information supplied in and with this application form is complete and accurate to the best of the applicant's knowledge and belief;
3. If it is granted registration as a service provider, the applicant will comply with Generation Health Service Provider policy and Fund rules
4. The applicant will notify Generation Health of all material changes to the information contained in and with this application form within 30 days of the change;
5. The applicant understands and agrees that if no business is placed at Generation Health within a reasonable timeframe, determined at the discretion of Generation Health, it may be deactivated as a service provider;

Please provide copies of the following:-

1. AHFoZ registration letter;
2. Current TAX Clearance;
3. Copy of National ID;
4. Proof of banking details.

Service provider representative:_____ **Signature:**_____

Date:_____

Service Provider Stamp