Electronic Bank Transfer Form

Member Details

Member No.

Scheme Name

Company Name

Name

N.I.C

Postal Address

Telephone No. Mobile No.

E-mail Address

Would you like to receive your payment resumé by e-mail? Yes No

Bank Details

Bank Name

Account Number

Account Holder Name

I hereby authorise Mosanté to effect payment of my medical insurance claims in the above bank account.

Signature Date

Office Use Only : Effective Date

Processed by Date

Verified by Date

OP-FT-47 V:03