CMCLF006

Cellmed Health Medical Fund

PROVIDER BANKING DETAILS

Please furnish us with your banking details to facilitate direct deposits into your bank account.

NAME OF SERVICE PROVIDER	
AHFoZ NUMBER	
BANK ACCOUNT NAME	
BANK NAME	
ACCOUNT NUMBER	
BANK BRANCH NAME	
BANK BRANCH CODE	

We would also request that you provide us with the following contact details so as to facilitate communication with you.

PHYSICAL ADDRESS	
POSTAL ADDRESS	
MOBILE NO.	
OFFICE NO.	
EMAIL ADDRESS	

This certifies that the above information is true and that Cellmed Health Medical Fund will not be held liable for incorrect details availed to them.

FULL NAME			
SIGNATURE		**DATE**	
DESIGNATION			
PROVIDER'S STAMP			