

# Electronic Bank

# Transfer Form

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## MEMBER DETAILS

Company Name

Family Name

First Name

Membership No.

N.I.C

Postal Address

Telephone No.  Mobile No.

E-mail Address

## BANK DETAILS

Bank Name

Account Number

Account Holder Name

I hereby authorise Business Mauritius Provident Association 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