

**Purpose of Document:**

This will enable our team to verify accuracy of the monthly billing for your organisation

# Endorsement Form

Page 1/1



 Business Mauritius Provident Association (BMPA) c/o Medscheme (Mtius) Limited (BRN:C07003574)  
Level No 1, Tower A, 1 Exchange Square, Wall Street, Ebene, 72201

 mosante@medschemeinternational.com

 403 50 60

 www.mosante.org

**Month Applicable:** \_\_\_\_\_ **Company Name:** \_\_\_\_\_

**SECTION A: ADDITIONS, DELETIONS & CHANGE IN PLAN**

Compulsory Fields					Additional Information as per Type of Request					
No.	Family Name	First Name	Type of Adjustments (Additions, Deletions or Change in Plans)	Membership No. (except for Additions)	Additions		Deletion	Change in Plan		
					Cover Start Date	Plan Chosen	Deletion Date	New Plan	Effective Date	New Monthly Contribution (MUR)
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

**SECTION B: CHANGE OF NAME & BANK ACCOUNT CHANGES**

Compulsory Fields					Additional Information as per Type of Request			
No.	Family Name	First Name	Type of Adjustments (Change of Name or Bank Account Changes)	Membership No. (except for Additions)	Change of Name		Bank Form Attached	
					New Registered Name	NIC Attached	Bank Form Attached	
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

\*Kindly submit the duly filled and signed Endorsement Form together with the relevant forms for Additions and Change in Plan to mosante@medschemeinternational.com by the 20th of each month to reflect in the billing for the next month.

HR Representative Name: \_\_\_\_\_ Date: \_\_\_\_\_

HR Representative Signature: \_\_\_\_\_