# MEDICAL BENEFITS SCHEME

## DIRECT CREDIT AUTHORISATION FORM

**All fields are mandatory. Please print . Incomplete forms will not be processed .**

### 1. BENEFICIARY INFORMATION

| | |
|---|---|
| Full Name (First Name/ Initial/ Last Name): | MBS #: |
| E-mail Address: | |
| Telephone Number:<br>(Home) (Work) (cell) | |

### 2. ACCOUNT INFORMATION

**Bank Name:** **Branch:** _____

| | | | |
|---|---|---|---|
| ACB | ☐ | SJCCU | ☐ |
| ECAB | ☐ | CFCCU | ☐ |
| FCIB | ☐ | SDACCU | ☐ |
| CUB | ☐ | Other: | _____ |
| BNS | ☐ | | |

**Name on Account:** _____

**Account Number:** _____

**Account Type:** **Chequing** ☐ **Savings** ☐

### 3. DECLARATION:

1. I hereby authorise Medical Benefits Scheme to credit my account with all payments due to me in settlement of claim(s).

2. Medical Benefits Scheme shall not be liable for any loss resulting from any inaccuracies included in the information provided.

**Signature of Beneficiary:** **Date:**

**FOR INTERNAL USE ONLY**

| | |
|---|---|
| Processed by: | Date: |
| Approved by:<br><br>Supervisor Customer Service | Date: |