

# Liberty Health Cover Service Provider Banking Details Change Request Form



LIFE INVESTMENTS HEALTH CORPORATE PROPERTIES ADVICE

## Important: please read the following before completing this application form

- Please write clearly using capital and block letters.
- It is compulsory to complete all the fields in this form.

Liberty Health Cover unique practice number	<input type="text"/>
Practice / Dr / Facility owner name	<input type="text"/>
Physical address	<input type="text"/>
Postal address (if different from physical address)	<input type="text"/> Postal code <input type="text"/>
	<input type="text"/> Postal code <input type="text"/>

## CONTACT DETAILS

Name of responsible person	<input type="text"/>
Telephone numbers (please include country and area code)	+ <input type="text"/>
Cellphone numbers (please include country and area code)	+ <input type="text"/>
Fax numbers (please include country and area code)	+ <input type="text"/>
Emergency contact telephone number	+ <input type="text"/>
E-mail address	<input type="text"/>
Internet access (tick correct)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Preferred communication method (tick your selection)	<input type="checkbox"/> Telephone <input type="checkbox"/> Mobile <input type="checkbox"/> Fax <input type="checkbox"/> E-mail <input type="checkbox"/> Post <input type="checkbox"/> Hand delivery

## CURRENT BANKING DETAILS

Account holder name	<input type="text"/>
Account number	<input type="text"/>
Account type	<input type="checkbox"/> Savings <input type="checkbox"/> Cheque <input type="checkbox"/> Transmission Other <input type="text"/>
Bank	<input type="text"/>
Branch name	<input type="text"/>
Branch code	<input type="text"/> Swift code <input type="text"/>
NIB (If applicable)	<input type="text"/>
IBAN (If applicable)	<input type="text"/>

