Liberty Health Cover
Service Provider Banking Details Change Request Form

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

Practice / Dr / Facility owner name

Physical address

Postal code

Postal address (if different from physical address)

Postal code

CONTACT DETAILS

Name of responsible person

Telephone numbers (please include country and area code) +

Cellphone numbers (please include country and area code) +

Fax numbers (please include country and area code) +

Emergency contact telephone number +

E-mail address

Internet access (tick correct) YES NO

Preferred communication method (tick your selection ☐ Telephone ☐ Mobile ☐ Fax ☐ E-mail ☐ Post ☐ Hand delivery

CURRENT BANKING DETAILS

Account holder name

Account number

Account type ☐ Savings ☐ Cheque ☐ Transmission Other

Bank

Branch name

Branch code Swift code

NIB (If applicable)

IBAN (If applicable)

NEW BANKING DETAILS

Account holder name

Account number

Account type: Savings / Cheque / Transmission / Other

Bank

Branch name

Branch code / Swift code

NIB (If applicable)

IBAN (If applicable)

Please attach the following documents

- Copy of the account holder's Identity Document/Passport/Drivers Licence.
- Copy of a bank stamped letter confirming banking details not older than 3 months.
- Signed and stamped letter from the provider confirming the request

DISCLAIMER: No banking details will be acceped without the abovementioned mandatory documents.

PROVIDER DECLARATION

I hereby declare the above to be true

Registration/Practice no.

Name

Signature

Date D D M M Y Y Y Y

Provider stamp

FOR OFFICIAL USE

FRONT OFFICE DECLARATION

I hereby declare that I have received and verified the above information with the required mandatory documents.

Name

Signature

Date D D M M Y Y Y Y

Front office stamp

Submitted to email address