

APPLICATION FOR DIRECT BANK PAYMENT FROM M.S.P.B.C. OR REQUEST FOR CHANGE TO BANKING INFORMATION
PERSONAL DATA

Your M.S.P.B.C. Payment Number

PAYMENT NUMBER

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(Note: Show either the GROUP or PHYSICIAN payment number)

 Surname or
Group Name _____

(Please Print)

Initials _____

AUTHORIZATION FOR DIRECT BANK PAYMENT FROM M.S.P.B.C.
I hereby authorize M.S.P.B.C. to make direct bank payment to me in the account indicated.

Applicant's Signature

Date

Telephone

Either attach a blank sample cheque, from the financial institute where you bank, with the fully MICR-ENCODED BRANCH, INSTITUTION and ACCOUNT NUMBERS; or the following section must be completed by a senior official at your bank.

PAYMENT DATA

Branch Number

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(must be 5 digits)
Note: Payment Data will be used for Direct Bank Payment.
Please be sure that all digits, including zeros, "0" are given.

Institution Number

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(must be 3 digits)

Account Number

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Institution / Bank Name _____

Branch Name _____

Street Address _____

City _____

Province _____

Postal Code _____

Telephone _____