CELLMED HEALTH
MEDICAL FUND

PROVIDER BANKING DETAILS

PLEASE PROVIDE YOUR BANKING DETAILS TO FACILITATE DIRECT DEPOSITS INTO YOUR BANK ACCOUNT.

PROVIDER DETAILS

Name of Service Provider:

AHFoZ Number:

Bank account name:

Bank name:

Account number:

Bank branch name:

Bank branch code:

Account Currency: ◯ ZWL ◯ USD

We would also request that you provide us with the following contact details so as to facilitate communication with you.

Physical address:

Postal address:

Mobile No.:

Office No.:

Email address:

This certifies that the above information is true and that Cellmed Health Medical Fund will not be held liable for incorrect details availed to them.

Full name:

Signature SIGN HERE

Designation

Date: dd/mm/yyyy

PROVIDER"S STAMP:

CELLMED HEALTH
MEDICAL FUND