RAFFLES SHIELD - POLICY SERVICE REQUEST FORM

	Received Date:

FOR OFFICIAL USE ONLY

In accordance with Section 25(5) of the Insurance Act, you must fully and faithfully reveal all facts which you know or ought to know (required in the application form or any future amendments to it). Failure to do so may result in you receiving nothing from the policy and / or the insurance policy and endorsement (if any) may be void.

Basic Policy Number:		**Rider Policy Number**:	
Advisor / Agent / RHA's Name			
RHI Code		**Mobile Number**	
RNF Number		**Company Name**	
Channel	☐ Direct ☐ Broker		

➔ **Only Policyholder can complete this form.**

➔ **You can submit this form through any 1 of these channels: (We do not accept email or photocopies.)**

1) **By Post to:**

Policy Servicing Department
Raffles Health Insurance Pte Ltd
25 Tannery Lane
Singapore 347786

2) **By Hand to your Financial Advisor.**

Please take note of the following before you proceed:	
Upgrade of Plan / Additional of Rider/Options	i. Your health will be assessed by us. RHI reserves the right to: - Approve of the service request without any further conditions; - Approve of the service request with exclusion(s) and/or additional premium payable; or - Postpone / Decline of the service request ii. There is a 40 days period from the cover Start Date of your new Integrated policy or Effective Date of your last change of plan (whichever is applicable) where you are not allowed to upgrade your plan. iii. The current plan must be fully paid before the service request can be processed and take effect. iv. New policy number will be issued for additional of rider. v. All rider applications approved during the three months period before your RHI Shield policy is due for renewal, the rider effective date will be on the renewal date.
Downgrade of Plan / Removal of Rider/Options	i. There is a 40 days period from the cover Start Date of your new Integrated policy or Effective Date of your last change of plan (whichever is applicable) where you are not allowed to downgrade your plan. ii. The current plan must be fully paid before the service request can be processed and take effect.
Termination	i. In the event that you cannot afford, or do not wish to continue paying the premiums for your Integrated Shield Plan, you can decide to cease your Integrated Shield Plan. If you are a Singapore Citizen or Permanent Resident, you will continue to be covered by MediShield Life for life without any exclusion, regardless of your decision on your Integrated Shield Plan. For more details on your coverage, please visit www.medishieldlife.sg. ii. For cancellation of policy upon expiry, policyholder must complete the service request form and submit to RHI, 2 weeks before the renewal date. iii. All service request form which are received after the renewal date, the policy will be terminated based on the form receipt date and the refund will be pro-rated.

Raffles Health Insurance Pte Ltd
(Registration No. 200413569G)
Corporate Office: 585 North Bridge Road #11-00 Raffles Hospital Singapore 188770
Correspondence Address: 25 Tannery Lane Singapore 347786 | Tel: 68126500 Fax: 68126615 | Website: www.raffleshealthinsurance.com

1. MY SERVICE REQUEST

☐ Upgrade of Plan	☐ Termination	☐ Change of Policyholder
☐ Additional of Rider/Options	☐ Reinstatement	☐ Premium Payment Mode/Method
☐ Downgrade of Plan	☐ Update of Personal Particulars	☐ Other Request(s)

2. UPGRADE OF PLAN / OPTIONS

Please choose your plan to upgrade to:
* Select your main plan to upgrade

☐ Raffles Shield Private* ☐ High Deductible	☐ Raffles Shield Plan B* ☐ High Deductible	**Note:** i. For upgrade of plan, please complete the Know Your Client (KYC) and Health Declaration Form in the attachment, subject to full underwriting. ii. To exercise the eligibility of your 'Guaranteed Upgrade' benefits, please refer to the Product Summary. iii. Credit Card payment is currently not allowed for upgrade of plan/option.
☐ Raffles Shield Plan A* ☐ Raffles Hospital ☐ High Deductible	☐ Raffles Shield Standard*	

3. ADDITIONAL OF RIDER

Please choose your type of rider:

☐ Key Rider - Not applicable for High Deductible Option	☐ Premier Rider	**Note:** For addition of rider, please complete the Know Your Client (KYC) and Health Declaration Form in the attachment, subject to full underwriting.

4. DOWNGRADE OF PLAN

Please choose your type pf plan to downgrade to:
* Select your main plan to upgrade

☐ Raffles Shield Plan A* ☐ Raffles Hospital ☐ High Deductible	☐ Raffles Shield Plan B* ☐ High Deductible	☐ Raffles Shield Standard*

5. TERMINATION

Please choose your type of plan(s) to terminate:

☐ RHI Shield Plan		**Note:** i. If RHI Shield Plan is terminated, the options / rider attached will also be terminated. ii. Removal of Options can only be done during renewal of RHI Shield Plan. iii. High Deductible option not allowed to add again once removed.
☐ Raffles Hospital	☐ High Deductible	
☐ Key Rider	☐ Premier Rider	

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6. REINSTATEMENT

Please choose your type of plan to reinstate:

		Note
☐ RHI Shield Plan		**Note:** i. For policy that has been terminated for more than 30 days, please complete the Know Your Client (KYC) and Health Declaration Form in the attachment, subject to full underwriting. ii. Reinstatement is disallowed if policy is terminated for more than 12 months. iii. Credit Card payment is currently not allowed for Reinstatement.
☐ Raffles Hospital	☐ High Deductible	
☐ Key Rider	☐ Premier Rider	

7. UPDATE OF PERSONAL PARTICULARS

- For Policyholder:

New Address				<<Postal Code>>
Mailing Address	<<If different from New Address>>			<<Postal Code>>
Mobile Number	+		**Home Number**	+
Email Address				

- For Insured:

New Address				<<Postal Code>>
Mailing Address	<<If different from New Address>>			<<Postal Code>>
Mobile Number	+		**Home Number**	+
Email Address				

8. CHANGE OF POLICYHOLDER

Details of NEW Policyholder:

			Note
Name of Policyholder			**Note:** i. The change of new policyholder will take effect from renewal or, when there is an upgrade or downgrade of plan (if it applies). ii. The change applies to both RHI Shield Plan and Rider (if any). iii. Please submit a photocopy of NRIC / FIN for new Policyholder for verification.
Date of Birth (DDMMYYYY)	/ /	**Sex** ☐ M ☐ F	
Citizenship	☐ Singaporean / PR ☐ Foreigner		
NRIC/FIN/Passport Number			
CPF Account Number			
Relationship of Insured to Policyholder	☐ Self ☐ Child ☐ Parent ☐ Spouse		

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9. PREMIUM PAYMENT MODE / METHOD

Please choose your type of payment method:

☐ Giro ☐ Cash/Cheque

Note:
i. Applies to Rider and/or outstanding premium above withdrawal limit for RHI Shield Plan on renewal.

ii. To apply for GIRO, please complete the GIRO request form.

10. OTHER REQUEST(S)

Please specify below:

I authorise RHI to effect a Change of Insurance Adviser for the captioned policy/policies to InsureDIY Pte Ltd.

AUTHORIZATION & DECLARATION TO CENTRAL PROVIDENT FUND BOARD (CPFB)

I authorize the Central Provident Fund Board (the "CPFB") to

(i) Deduct premium(s) due for the Life/Lives to be Assured as named under this application (the "Life/Lives to be Assured") from my Medisave account (including any new Medisave account(s) which I may have arising from obtaining Singapore Permanent Resident status or otherwise) in accordance with the provisions of the Central Provident Fund Act (Chapter 36), the MediShield Life Scheme Act (Act No. 4 of 2015) and the respective subsidiary legislation made thereunder and as amended from time to time and subject to all terms and conditions as may be imposed by the CPFB from time to time for the purposes of the Private Medical Insurance Scheme (or by such other name as it may be referred to from time to time) (PMIS).

(ii) Disclose/seek information on a confidential basis to/from any insurer(s) for the PMIS in respect of the insurance cover issued following this application. Such information includes but is not limited to:

(a) Payment and amount of premiums due, including the deduction of premiums from my MediSave account and my MediSave account balance; and

(b) the making of refunds under the PMIS, as the CPFB shall reasonably consider appropriate; and

(c) The amount of premium subsidies for the Life/Lives to be Assured and the amount of additional premium applicable to the Life/Lives to be Assured.

I and the Life/Lives to be Assured named under this application, hereby consent to the transfer and disclosure, at any time and without notice to me/us, of any medical information on me/us, in the Insurer's or the CPFB's possession, between the Insurer and the CPFB, for the purpose of assessing the insurability of me/us and/or the making of a claim under the PMIS.

Subject to the relevant laws and terms and conditions, I or We understand that

(i) Upon the commencement of this RHI Shield cover, any other existing Integrated Shield Plan (if any) under the PMIS in favour of the Life/ Lives to be Assured shall automatically terminate; and

(ii) Upon the commencement of another Integrated Shield Plan in favour of the Life/Lives to be Assured, this RHI Shield cover of the Life/Lives to be Assured shall automatically terminate.

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AUTHORIZATION & DECLARATION TO RAFFLES HEALTH INSURANCE PTD LTD

A. Declaration and Authorization

a) The answers and statements given in this service request form , together with any required questionnaire or amendments ("the information") are full, complete and true, and whether written by me / us or by anyone else on my / our behalf. I / We hereby accept full responsibility for them; and agree that they shall form part of my / our proposal, which shall by the basis of the contract of insurance.

b) I / We have not withheld any material information in completing this proposal.

I / We understand that benefits will not apply to treatment or expense arising from medical conditions which originated or were known to exist for which treatment, medication, advice or diagnosis was sought or received prior to my/our enrolment in the Policy unless such conditions are fully disclosed to an accepted by Raffles Health Insurance Pte Ltd prior to the inception of the Policy.

I / We understand that my / our application will be subject to acceptance by Raffles Health Insurance Pte Ltd, and that I / We will not be insured under any of the insurance plan(s) for which I/We are subject to acceptance until Raffles Health Insurance Pte Ltd advises I / Us the terms and conditions on accepting insurance on I / Us, and that Raffles Health Insurance Pte Ltd reserves the right to decline insurance or impose special terms and conditions.

I / We were duly informed that any payment made at the time of this proposal or thereafter shall be construed as a deposit (free of interest) and be held by you until an unequivocal acceptance of this proposal from you.

I / We understand that:

a) If my / our application for insurance under any of the above plan(s) is accepted, my / our Insurance under the plan shall terminate if the Policyholder does not renew the plan upon expiry of any period of Insurance, or cancel the plan(s), or if I / We attain the age at which the Insurance terminated as specified in the terms and conditions of the Insurance plan(s), and

b) These plan(s) are yearly renewable and that the terms and conditions of the Insurance plan(s) I/We are insured under, including the premium payable, at any renewal of the plan(s), may change upon agreement between the Policyholder and Raffles Health Insurance Pte Ltd.

I / We agree that the policy is issued as a Singapore Policy (unless stated otherwise under Table 1) expressed in Singapore dollars and all payments under the policy, whether to or by you will be payable in Singapore dollars in Singapore dollars in Singapore. I / We also agree that the policy will be entered in the register of Singapore policies (unless stated otherwise under Table 1).

Table 1

This policy shall be deemed as an "Singapore Policy" if the individual,

i) Is a citizen of Singapore, unless he has resided outside Singapore continuously for 5 or more years preceding the proposal date of the policy and is not currently residing in Singapore;

ii) Is a permanent resident, unless he has resided in Singapore for less than a total of 183 days in the 12 months preceding the proposal date of the policy;

iii) Has a work pass or permit required under the Employment of Foreign Manpower Act (Cap. 91A), unless he has resided in Singapore for less than a total of 183 days in the 12 months preceding the proposal date of the policy; or

iv) Has a pass or permit required under the Immigration Act (Cap. 133) that has a duration longer than 90 days and has resided in Singapore continuously for at least 90 days in the 12 months preceding the proposal date of the policy.

I / We hereby authorize any hospital, medical practitioner, clinic or other medical related facility, insurance company or other organisations or persons to release to you any information concerning my / our medical condition or history.

I / We confirm that I / We have been given a copy of the booklet "Your Guide to Health Insurance" and read through the Product Summary, the contents of which have been explained to me to my / our satisfaction. [Not applicable for Direct Marketing].

B. Personal Data Protection Notification

I / We acknowledge that:

1. To process, administer and / or manage My / Our relationship, account and policy with Raffles Health Insurance Pte Ltd. You will necessarily need to collect, use, disclose and/or process My / Our personal data or personal information about Me / Us. Such personal data includes:
   i) Information set out in this proposal / application form and ant other personal information provided by Me / Us or possessed by Raffles Health Insurance Pte Ltd and (ii) my / our claims.

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AUTHORIZATION & DECLARATION TO RAFFLES HEALTH INSURANCE PTD LTD (Continue from Page 5)

2. Such personal data will be collected, used, disclosed and / or processed by Raffles Health Insurance Pte Ltd for the purpose(s) of:
   a) Considering whether to provide Me / Us with the insurance I / We applied for;
   b) Processing My / Our application for underwriting and insurance;
   c) Administering and / or managing My / Our relationship, account and / or policy with Raffles Health Insurance Pte Ltd;
   d) Processing and / or dealing with any claims including the settlement of claims and any necessary investigations relating to the claims, under My / Our policy;
   e) Carrying out due diligence or other screening activities (including background checks) in accordance with legal or regulatory obligations of risk management procedures that may be required by law or that may have been put in place by Raffles Health Insurance Pte Ltd;
   f) Carrying out My / Our instructions or responding to any enquiries by Me / Us;
   g) Dealing in any matters relating to the services and / or products which I / We are entitled to under this policy which I / We are applying for or have applied; (including the mailing of correspondence, statements, invoices, reports or notices to Me / Us, which could involve disclosure of certain personal data about Me / Us to bring about delivery of the same as well as the external cover of envelopes / mail packages);
   h) Investigating fraud, misconduct, any unlawful action or omission, whether relating to My / Our application, My / Our claims or any other matter relating to My / Our policy, and whether or not there is any suspicion of the aforementioned; and / or
   i) Complying with applicable law in administering and managing My / Our relationship with Raffles Health Insurance Pte Ltd.
   j) Sending me marketing, advertising and promotional information about other insurance, investment and/or financial products and/or services that Raffles Health Insurance Pte Ltd may be selling or marketing, and which Raffles Health Insurance Pte Ltd believes may be of interest or benefit to me, by the following modes of communication:
      - Postal mail, electronic transmission to my email address, SMS / MMS (text message) and fax;
      ☐ Please tick this box if you do not wish to receive communication via postal mail, email, SMS/MMS (text message) and fax.
      - To my telephone number(s) : ______________________; ______________________; __________________ by way of:
      ☐ voice call (Please tick this box if you do not wish to receive communication via voice calls)

3. By signing on this proposal or application form, I / We consent to Raffles Health Insurance Pte Ltd in:
   a) collecting, using, disclosing and / or processing My / Our personal data for the Purposes as described above;
   b) collecting personal data about Me / Us from sources other than Myself/Ourselves and using, disclosing and / or processing the same, for one or more of the purposes as described above;
   c) disclosing My / Our personal data to its third party service providers, or agents (including its lawyers / law firms), for the Purposes as described above; and
   d) transferring My / Our personal data out of Singapore to its third party service providers, or agents where such third party service providers or agents are sited (whether in Singapore or outside of Singapore), for the Purposes as described above.
   e) representing and warrant that My / Our personal data provided in this form, for the purpose as described above and have read and understood the above provisions.

Important Note: Individuals aged 16 and above are required to provide consent for the collection use and disclosure of their personal information.

Name of Existing Policyholder	Name of Life Assured	Name of New Policyholder
NRIC/FIN	NRIC/FIN	NRIC/FIN
Signature of Existing Policyholder#	Signature of Life Assured#	Signature of New Policyholder
Signature Date / /	Signature Date / /	Signature Date / /

 # The signature of Policyholder / Life Assured should be signed in the same manner as they appear in our records

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HEALTH DECLARATION FORM

CURRENT LIFESTYLE AND HEALTH

Part I Please complete this section below. If yes to any, please indicate in the **NOTES Section.**	**Yes**	**No**
1. Height (Metres)		
2. Weight (Kilograms)		
3. Have you experienced any abnormal weight gain or loss (more than 20 kg) over the last 6 months?		
4. Have you smoked more than 20 cigarettes (average) a day over the last year?		
5. Do you drink more than 20 glasses (average) of alcohol (beer/wine/whisky etc.) in a week?		
6. Have you ever taken drugs, narcotics, sniffed glue or been treated for drug addiction?		
7. Have you ever been diagnosed with HIV or Hepatitis C?		
8. Has any of your natural parents or siblings suffered or died from cancer, stroke, hypertension, heart disease, liver disease or kidney disease?		
Have you ever had, or been told to have, or been treated for:		
9. Diabetes?		
10. Hypertension (high blood pressure)?		
11. Hyperlipidaemia (high cholesterol)?		
If the answers to any of **Questions 9, 10 and 11 are "Yes"**, please proceed to **Part II of Underwriting Questions** **Otherwise**, please proceed to **Part III of the Underwriting Questions**.		

Part II Please complete this section below. **Please declare any additional medical history/conditions in the NOTES Section**.	**Yes**	**No**
Diabetes		
9a. Have you ever been admitted to hospital for diabetic related complications such as amputation, kidney failure, coma, etc.?		
9b. Are you a Type 1 diabetic or do you require insulin injections?		
9c. Is your HbA1c more than 7.5%?		
Hypertension (high blood pressure)		
10a. Is your average blood pressure reading ≥180/110 mmHg?		
Hyperlipidaemia (high cholesterol)		
11a. Is your Total Cholesterol:		
< 300 mg/DL (7.75 mmol/L)?		
between 300 - 400 mg/DL (7.75 - 10.3 mmoL)?		
> 400 mg/DL (10.3 mmol/L)?		
11b. Is your Total Triglycerides:		
< 399 mg/DL (4.4 mmol/L)?		
between 399 - 600 mg/DL (4.4 - 6.77 mmoL)?		
> 600 mg/DL (6.77 mmol/L)?		

CURRENT LIFESTYLE AND HEALTH *(continued)*		
Part III Please complete this section below. **Please declare any additional medical history/conditions in the NOTES Section**.	**Yes**	**No**
Have you ever had, or been told to have, or been treated for:		
12. Cardiovascular / heart disorder?		
13. Respiratory / lung disorder?		
14. Endocrine / metabolic disorder?		
15. Neurological / brain / spine / nerve disorder?		
16. Psychological / mental disorder?		
17. Gastroenterological / digestive disorder?		
18. Cancer?		
19. Liver disorder?		
20. Kidney or bladder disorder?		
21. Bones, joints or skin disorder?		
22. Blood disorder?		
23. Eye, ear, nose or throat disorder (excluding long and short sightedness)?		
24. Bleeding disorder from anus or rectum?		
25. Any other medical conditions not listed above? If so, please kindly specify in the Notes section		

Please complete the questions below if the Insured is a female, age 16 and above: **Please declare any additional medical history/conditions in the NOTES Section**.	**Yes**	**No**
26. Have you suffered from or are you aware of any breast lumps or any other disorders of your breasts?		
27. Have you been tested positive for BRCA 1 or 2 gene or have any of your immediate family members been diagnosed with breast cancer?		
28. Have you suffered from any disorders of the female organs? For example, uterine fibroids, ovarian cysts, polycystic ovarian syndrome (PCOS), uterine polyps etc.		
29. Have you ever had any abnormal pap smear test or been told by any doctor to have a repeat pap smear within the last six months?		
30. Were there any complications during any of your pregnancy such as gestational diabetes, hypertension, etc.?		
31. Are you pregnant now? (if yes, please state your estimated delivery date)		

Applicable for Raffles Medical Group / Raffles Hospital Patients

☐ **I / We hereby authorize and consent to Raffles Health Insurance Pte Ltd to obtain from Raffles Medical Group Ltd and Raffles Hospital Pte Ltd, any information concerning my / our medical condition(s) or history for the purposes of this policy / policies and / or policy application(s), which may include but is not limited to underwriting, policy renewal and communication with insurance offices or organisations, reinsurers or investigators for claims, reinsurance and compliance / audit purposes.**

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DEBIT / CREDIT CARD AUTHORISATION FORM

Important Notes:

1. **This form is to be completed by the Policyholder for the purpose of instructing Raffles Health Insurance Pte Ltd on premiums payment matters.**
2. For full details of the purposes of collection, use, disclosure and processing of your personal data, please visit: https://www.rafflesmedicalgroup.com/insurance/resource-centre/privacy-statement ("**Personal Data Notice**").
3. Please complete this form and return to Raffles Health Insurance Pte Ltd.
4. Debit / Credit Card payments are accepted only for the FIRST year's premium. Debit / Credit Card payments for renewal premium policies will NOT be accepted.
5. If the Debit / Credit Cardholder is not the Policyholder, he / she has no rights to enforce any terms and conditions of the named Policy (ies) in this form under the Contract (Rights of Third Parties) Act, Cap 53B.

Section A: To be completed by Policyholder

Name of Policyholder (as per NRIC/ FIN/ Passport):	**NRIC/ FIN/ Passport No.:**
Address:	**Mobile No.:**
Relationship between Policyholder and Debit / Credit Cardholder:	

POLICY DETAILS

Proposal/ Policy No.	Particulars of Insured(s), including the Policyholder's		
	Name of Insured (as per NRIC/ FIN/ Passport)	NRIC /FIN/ Passport No.	Relationship to Policyholder
			Self
			Spouse

By signing on this form,

1. I, the Policyholder confirm that I have read, understand and agree to the Personal Data Notice and confirm that I have the authority and consent to provide personal information of Insured persons listed on this form in relation to this payment instruction and authorisation.
2. I, the Policyholder further give consent to Raffles Health Insurance Pte. Ltd. ("RHI") to collect, use, disclose personal data provided in this form for the purpose of processing, administering and managing the policy or policies that I maintain with RHI in compliance with applicable law.
3. I, the Policyholder certify that the information provided in this form is true and correct and that no material information or circumstances have been withheld or omitted.

Signature of Policyholder:	**Date:**

Section B: To be completed by Debit / Credit Cardholder.

☐ **Debit / Credit Card** (please complete section on Debit / Credit card authorisation below)
The issuing bank of the Debit / Credit Card must be domiciled in Singapore.

DEBIT / CREDIT CARD AUTHORISATION		
Name of Debit / Credit Cardholder (as shown in NRIC/ Passport/FIN No.):		**NRIC/Passport/FIN No.:**
Debit / Credit Card No.:		
Name Imprinted on Debit / Credit Card:		
Issuing Bank:	**Card Expiry/ End Date:**	**Card Type:** ☐ Master ☐ Visa
Address of Debit / Credit Cardholder (if address differs from Section A):		

By signing on this form,

1. I, the Debit / Credit Cardholder, hereby authorise Raffles Health Insurance Pte. Ltd. to charge the premium(s), including extra premium or charges (if any), to my Debit / Credit card account for this/ these insurance policy (ies) maintained with Raffles Health Insurance Pte. Ltd.. This authorisation shall remain in effect until I terminate it by written notification to Raffles Health Insurance Pte. Ltd. at least 30 days in advance of the intended date of termination.
2. I, the Debit / Credit Cardholder fully understand and agree that for any refundable premium will be paid to the Policyholder of the policy/ policies stated above and I will not contest Raffles Health Insurance Pte. Ltd. for the refund of the premium.
3. I, the Debit / Credit Cardholder confirm that I have read, understand and agree to the Personal Data Notice and give consent to Raffles Health Insurance Pte. Ltd. for the collection, use and disclosure of my personal data as set out in the Personal Data Notice and this authorisation.
4. I, the Cardholder certify that the information provided by me in this form is true and correct and that no material information or circumstances have been withheld or omitted.

Signature of Debit / Credit Cardholder:	**Date :**

Conditions:

a) Debit / Credit Card payments are accepted only for the FIRST year's premium. Debit / Credit Card payments for renewal premium policies will NOT be accepted.

b) If the Cardholder is not the Policyowner , he / she has no right under the Contract (Rights of Third Parties) Act, Cap 53B, to enforce any of the terms and conditions of that policy.

RafflesHealthInsurance
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Version 1.0
112019

INTERBANK GIRO APPLICATION FORM

Please complete PART 1 of this form and return to the Billing Organisation.

Part 1: For Applicant's Completion (fill in the spaces indicated with a √)	
√ Date:	√ Name of Billing Organisation ("BO"): RAFFLES HEALTH INSURANCE PTE LTD
√ To: Name of Bank / Finance Company:	√ BO's Customer Name, NRIC/FIN No. & Relation to the Insured:
√ Branch:	√ BO's Customer Reference No:

(a) I/We hereby instruct you to process the BO's instructions to debit my/our account.
(b) You are entitled to reject the BO's debit instruction if my/our account does not have sufficient funds and charge me/us a fee for so doing. You may also, at your discretion, allow the debit even if this results in an overdraft on the account and impose charges accordingly.
(c) This authorisation will remain in force until terminated by your written notice sent to my/our address last known to you or upon receipt of my/our written revocation through the BO.

My/Our Name(s):

√_________________________________

My/Our Contact Tel/Fax/Handphone/Pager No(s):

√_________________________________

My/Our Account No:

√_________________________________

My/Our Company Stamp/Signature(s)/Thumbprint(s):

√_________________________________
(As in Bank/Finance Company's records)
* For thumbprints, please go to branch with your identification.

Part 2: For Billing Organisation's Completion

Bank				Branch			BO's Account No										
7	1	7	1	0	0	3	0	0	3	9	5	4	7	6	9	2	

Bank				Branch			Account No to be debited									

BO's Customer Ref No									

Part 3: For Bank / Finance Company's Completion

To: The Manager (Name & Address of BO)

Attn:

This application is hereby REJECTED (please tick) for the following reason (s):

[ ] Signature/Thumbprint # differs from Bank's/Finance Co's records
[ ] Signature/Thumbprint # incomplete/unclear #
[ ] Account operated by signature/thumbprint #
[ ] Wrong account number
[ ] Amendments not countersigned by customer
[ ] Others: ____________________________

_______________________________ Name Of Approving Officer
_______________________________ Authorised Signature
_______________________________ Date

 # Please delete where inapplicable

A member of RafflesMedicalGroup

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