



BRITISH
COLUMBIA

Health
InsuranceBC

**APPLICATION FOR DIRECT BANK PAYMENT
FROM MEDICAL SERVICES PLAN (MSP)
or REQUEST FOR CHANGE OF BANKING INFORMATION**

PERSONAL DATA

Your MSP Payment Number

RESERVED 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 MSP

I hereby authorize MSP to make direct bank payment to me in the account indicated.

Applicant's Signature

Date

Telephone

Attach a blank sample cheque from the financial institution where you bank, make sure the cheque is fully MICRO-ENCODED with **BRANCH, INSTITUTION** and **ACCOUNT NUMBERS**.

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

Mailing Address: Provider Programs, PO Box 9480 Stn Prov Govt, Victoria BC V8W 9E7
Tel: (Lower Mainland) 604 456-6950, (Rest of BC) 1 866 456-6950, Fax: 250 405-3592 Web: www.hibc.gov.bc.ca