NEW BRUNSWICK MEDICARE
APPLICATION FOR DIRECT DEPOSIT SERVICE

TO BE COMPLETED BY PRACTITIONER - PLEASE PRINT

NAME _____ PHYSICIAN NO. _____

Surname Given Name

MAILING ADDRESS _____ POSTAL CODE _____

I, THE UNDERSIGNED, AUTHORIZE YOU TO DEPOSIT MEDICARE PAYMENTS INTO MY BANK ACCOUNT

SIGNATURE: _____ DATE: _____

If you have personalized cheques on which your name and account number is printed you can simply attach a blank one to this application. (Please write "VOID" across the face of the cheque.) Otherwise, the section below must be completed and validated by your bank or financial institution.

TO BE COMPLETED BY BANK / FINANCIAL INSTITUTION - PLEASE PRINT

TRANSIT NO. & BANK IDENTIFICATION _____ ACCOUNT NO. _____ TYPE OF ACCOUNT _____

BANK / FINANCIAL INSTITUTION NAME: _____

ADDRESS: _____

AUTHORIZED SIGNATURE _____ DATE _____

VALIDATION STAMP