KNOW YOUR CUSTOMER FORM – GEASO HEALTH PLAN

Employee Name: _____
FIRST NAME MIDDLE INITIAL MAIDEN NAME SURNAME

TRN: _____-_____-_____ **Email Address:** _____

DOB.: _____/_____/_____ **GENDER: M** ☐ **F** ☐ **Mobile. No.:** _____
MM DD YY

Current Mailing Address:_____

_____

Name of Ministry & Location: _____

POLICY/CARDHOLDER NO.: 0000910000 -_____- _____ **EMP. NO.:** _____

ELECTRONIC FUND TRANSFER – This will solely be used for the purpose of health claims payment:

BANK DATA	
Name of Bank/Financial Institution:	
Name of Account Holder:	
Branch:	
Address of Bank:	
Account Number:	
Account Type:	**Savings: _____ Chequing: _____ Other:_____**

Employee's Signature: _____ **Date:** _____

Witness By:

Signature of HR/Accounts Rep.: _____ **Date:** _____

Name of HR/Accounts Rep.: _____