

PAYMENT INSTRUCTION (Proceeds is only paid to Member)

Bank-in

Bank : _____

Branch : _____

Account No. : _____

Mail cheque to correspondence address as per Provider's record

(Please fill up a separate form for change of correspondence address)

DECLARATION AND SIGNATURES

1. I hereby confirm that I have read and understand the contents of this form and that all information provided by me and any subsequent alterations thereof are true and accurate.
2. I undertake to notify the PRS Provider if there are any changes to the information provided.
3. I hereby acknowledge that I am aware of the fees and charges that I may incur directly or indirectly when withdrawing from any of the funds.
4. **I understand that by providing false or misleading information, document or in which there is material omission to the PPA or PRS Provider, I am committing an offence under Section 139ZO of the Capital Market Services Act, and may be imprisoned not exceeding three years or to a fine not exceeding one million ringgit or to both.**
5. I acknowledge and accept that the PRS Provider has absolute discretion to rely on this confirmation from me.

Signature of Member / Applicant*

Date (DD/MM/YY)

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For Thumbprint Verification

(Please refer to Section 1.0 of the Guide)

Signature of the Attending Doctor

Name of the Attending Doctor:

Date:

Hospital Official Stamp

***Applicant refers to:**

Persons appointed by the courts or through power of attorney to manage the affairs of the member (for withdrawal due to PTD/ Serious Disease/ Mental Disability).

For Office Use Only

CONSULTANT/STAFF CODE: _____

BRANCH NAME & CODE: _____

CONSULTANT/STAFF NAME: _____

SIGNATURE: _____

CONSULTANT/STAFF H/P NO.: _____

DATE: _____