

705 Serangoon Road, Singapore 328127 Tel: 62946592, 62946603

**COMPLETE PART I AND RETURN THIS FORM TO KWONG WAI SHIU HOSPITAL**

**PART I**

To: The Manager

(Name & Address of My/Our Bank)

好！我将每月捐助广惠肇留医院 Yes! I would like to contribute to Kwong Wai Shiu Hospital every month.	银行户口号码 My/Our Bank Account No
银行及分行 Bank & Branch Name	地址 My Address _____
银行户口姓名 My/Our Name (as in bank account)	_____ 邮区 S'pore _____
Limit of each monthly GIRO deduction (exclude cents) * <input type="checkbox"/> \$10 <input type="checkbox"/> \$20 <input type="checkbox"/> \$30 <input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> other amount \$ _____	身份证/护照号码 Donor's IC/Passport No
Kwong Wai Shiu Hospital's OCBC Bank A/C No. <b>7339 • 521 • 049569 • 002</b>	电邮 E-mail: _____
	电话 Tel: _____
	Kwong Wai Shiu's Donor's Reference No. ** <b>KWSH</b>

I/We hereby authorize you to confirm acceptance/rejection of my DDA to Kwong Wai Shiu Hospital and further authorize Kwong Wai Shiu Hospital to initiate and you to process debits to my/our account each not exceeding the limit indicated even though this may result in an overdraft or an increase of the overdraft on my/our account. You are entitled to dishonour such payments and may at your discretion levy a fee should my/our account not contain the necessary funds. You are under no obligation to ascertain the name on the record of Kwong Wai Shiu Hospital is the same as that provided by me/us and whether or not notice of the bill underlying the debit has been given to me/us.

This authorization shall continue in force until I/we have expressly revoked it by written notice delivered to you. You may in your absolute discretion terminated this arrangement by written notice delivered to my/our address last known to you.

I/We agree that you shall not be liable for any losses arising from or in any way connected with you so acting, provided that you act in good faith or unless directly caused by or resulting from you or your employees' wilful default or negligence.

\_\_\_\_\_ Date \_\_\_\_\_ My/Our Signature(s)  
[According to Bank's specimen signature(s)]

**TO BE COMPLETED BY KWONG WAI SHIU HOSPITAL**

**PART II**

Bank	Branch	Kwong Wai Shiu Hospital's Account No.	Kwong Wai Shiu Hospital's Donor's Reference No.
7 3 3 9	5 2 1	0 4 9 5 6 9 0 0 2	K W S H
Bank	Branch	Account No. to be debited	Limit of each monthly GIRO deduction (exclude cents)

To: Kwong Wai Shiu Hospital — Fund Raising Dept.  
705 Serangoon Road  
Singapore 328127

**PART III**

Bank	Branch	Kwong Wai Shiu Hospital's Account No.	Kwong Wai Shiu Hospital's Donor's Reference No.
7 3 3 9	5 2 1	0 4 9 5 6 9 0 0 2	K W S H
Bank	Branch	Account No. to be debited	Limit of each monthly GIRO deduction (exclude cents)

The Direct Debit Authorization in respect of the abovementioned account is hereby ACCEPTED/REJECTED. (Delete where appropriate.)  
If rejected, reason:

\_\_\_\_\_ Date \_\_\_\_\_ Authorised Signature  
Name of Approving Officer: \_\_\_\_\_  
Name of Bank: \_\_\_\_\_

\* Please indicate the maximum amount for each payment if you wish to set a limit for each payment.  
\*\* Please ensure that the reference number of the account you wish to credit is correct.  
 The shaded areas are for official use.

Verified by K.W.S.H