

---

Unique Mandate Reference (UMR) : UMR-CU1212-0007-5-1475405262

Creditor Identifier (Creditor Identifier - ICS) :

Creditor Name : WIAWSO MUNICIPAL HEALTH SERVICE STAFF WELFARE ASSOCIATION

Address :

SEFWI WIAWSO

SEFWI WIAWSO

Ghana

---

By signing this mandate form, you authorize (A) WIAWSO MUNICIPAL HEALTH SERVICE STAFF WELFARE ASSOCIATION to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instructions from WIAWSO MUNICIPAL HEALTH SERVICE STAFF WELFARE ASSOCIATION. As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. Your rights regarding the above mandate are explained in a statement that you can obtain from your bank.

---

(B) Please complete all the fields marked \*

Your name \* :

\_\_\_\_\_

Professional ID 1 \* :

\_\_\_\_\_

Address :

\_\_\_\_\_

Your Bank Account Name (IBAN) \* :

FR9999999999

Your Bank Identifier Code (BIC) \* :

CC12

Type of payment \* :

☐ Recurring payment or

☒ One-off payment

---

Date of signature

\_\_\_\_\_

Signature

\_\_\_\_\_

Please return this mandate form by email to  
neyoadasko@gmail.com or by mail to:

WIAWSO MUNICIPAL HEALTH SERVICE STAFF WELFARE  
ASSOCIATION  
SEFWI WIAWSO  
SEFWI WIAWSO  
Ghana