Electronic Funds Transfer Form – Health or Dental Service Provider

CLEAR FORM

Complete this form to receive payment or reimbursement by direct deposit. Please print.

1. Provider information

Clear Section

Service provider/Business name:

Service provided (optional):

Address:

Phone: W C Email:

Primary contact: Secondary contact:

New or existing provider? ☐ New ☐ Existing

Proof of entity attached (registration/tax ID or licence number) Registration or tax ID #: Licence #:

Type of entity: ☐ Partnership ☐ Sole proprietorship ☐ Limited company

2. Communication method

Clear Section

Preferred method of communication: ☐ Email ☐ Mail

3. Local bank information (complete for companies located in Bermuda)

Clear Section

Please provide the name of the service provider as it appears on the account. The account must be based in Bermuda and payable in Bermuda and payable in Bermuda dollars only.

Account name:

☐ HSBC account number:

☐ BNTB account number:

☐ Clarien account number:

4. Overseas bank account information (complete for overseas companies only)

Clear Section

The bank account must include the name of the Service Provider.

Beneficiary bank name: SWIFT or ABA code:

Beneficiary bank address:

Correspondent bank name (if required): SWIFT or ABA code:

Correspondent bank address:

Final beneficiary name (first/middle/last):

Final beneficiary address:

Final beneficiary account number:

IBAN number (for European, Middle Eastern and Caribbean countries):

Currency: ☐ USD ☐ CAD ☐ GBP ☐ EUR ☐ Other:

CLEAR PAGE

Authorisation and declaration

Authorised declaration and signature

By signing this form, I/we confirm/understand that:

- *The information provided on this form and attachments is true and complete.*
- *I/We authorise BF&M Life Insurance Company to automatically credit funds into the account provided above. Should the account details above change it is my/our responsibility to notify BF&M of the change.*
- *Any errors or omissions concerning the information provided on this form are my/our responsibility.*
- *This form certifies that the individual(s) referenced above are authorised parties on behalf of this account.*
- *A photocopy of this authorisation is as valid as the original.*

Data protection declaration

By signing this form, I/we confirm/understand that:

- *I/We consent to BF&M processing my/our personal data in accordance with BF&M's Privacy Policy (www.bfm.bm/privacy).*
- *I/We understand that I/we may withdraw my consent at any time by email to privacy@bfm.bm but that may impact BF&M's ability to provide insurance or related services or pay insurance claims benefits.*
- *If I/we have provided personal information relating to any third party, I/we confirm that I/we have received their consent for BF&M to process their personal information in line with the privacy notice.*

I/We submit this application and fully understand that by checking the "ACCEPT TERMS" box below, I/we confirm and (in my/our capacity as health or dental service provider) understand and agree with the declaration set out above.

☐ **ACCEPT TERMS**

Name 1:	
Sign:	Date (dd-mmm-yyyy):

Name 2:	
Sign:	Date (dd-mmm-yyyy):

Please return the fully completed forms and supporting documents to BF&M by any of these methods:

Mail: BF&M Life Insurance Company Limited, Attention: Customer Care, P.O. Box HM 1007, Hamilton HM DX, Bermuda
By hand: BF&M Life Insurance Company Limited, BF&M Insurance Building, Attention: Customer Care, 112 Pitts Bay Road, Pembroke HM 08, Bermuda
Email: eftinfo@bfm.bm or customercare@bfm.bm **Phone:** +1 441 298 0358 **Fax:** +1 441 296 8740

For BF&M official use only

Service provider tax ID: _____

Date processed: ___/___/___ Date scanned: ___/___/___ ZenD confirmed: ___/___/___ Admin: _____