|  |
| --- |
| **PROVIDER ELECTRONIC FUNDS TRANSFER (EFT) PAYMENT APPLICATION** |
| NAME OF PROVIDER(As registered with BahamaHealth): |  |
| Business License #: |   |  Issue Date: |  | Expiry Date: |  |
| Tax Identification # (TIN) |  |
| Business Address: |  |
| Primary Contact: |  | Job Title: |  |
| Office Phone: |  | Mobile Phone: |  |
| Email Contact: |  |
| Alternate Email Address: |  |

|  |
| --- |
| **BANKING INFORMATION FOR ELECTRONIC FUNDS TRANSFER** |
| Bank: |  |
| Exact Name on Account: |  |
| Account #: |  | Select account type:  |  ☐Savings ☐Checking |
| Branch Location: |  | Branch #: |  |

|  |
| --- |
| **COMPLETED BY:** |
| Name (Print): |  |
| Title: |  |
| Signature: |  |
| Date: |  |

Family Guardian Insurance Company Limited and BahamaHealth Insurance Brokers Limited accept no liability for the inaccuracy of any information stated herein, or for the consequences of any actions taken on the basis of any inaccurate information herein provided.  The signing of this form signifies your agreement that neither Family Guardian Insurance Company Limited nor BahamaHealth Insurance Brokers Limited will be liable to you in respect of any business loss resulting from any inaccurate information provided on this form, including but not limited to loss of profits, income, revenue, business, contracts, commercial opportunities or goodwill.

|  |
| --- |
| **FOR BAHAMAHEALTH USE ONLY** |
| **RECEIVED BY** | **DATE** |
| **RECEIVED BY** | **DATE** |
| **RECEIVED BY** | **DATE** |