Bahama Health
FEEL GOOD ABOUT YOUR HEALTHPLAN

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:	

Release of Liability

Family Guardian Insurance Company Limited (BahamaHealth) accepts 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 Family Guardian Insurance Company Limited (BahamaHealth) will not 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.

Completed forms are to be forwarded to hensia.mckinney@familyguardian.com.

FOR BAHAMAHEALTH USE ONLY

RECEIVED BY	**DATE**
ENTERED IN SYSTEM BY	**DATE**
REVIEWED BY	**DATE**