Health Insurance Department
Health Insurance Plan / FutureCare Plan
Direct Deposit Request Form

FOR OFFICAL USE

Reviewed By: _____

Date (d/m/y): _____

HID Manager Signature:

_____

Processed: ☐ Yes ☐ No

This Direct Deposit Request Form is to be used for local Bermuda claims only.

Please complete all fields, printing or typing information clearly

Contact Details	
Policyholder Name:	
Policy/Group ID:	
E-mail:	
Telephone (direct):	
Mailing Address (for Correspondence):	

Bank Details	
Bank Name: **(Bermuda Banks Only)**	
Name on Bank Account:	
Bank Account Number:	
Account Type: **(Chequing or Saving)**	

I hereby authorize the Health Insurance Department to satisfy payment obligations due to me/the Business Organization, by making deposits to the account indicated above. I understand that receipt of the electronic fund transfer(s) will fulfill the Health Insurance Department's payment obligation for the full amount on the date the fund transfer is completed. All correspondence with the Health Insurance Department concerning this agreement or any changes to account information should be sent to the address at the top of this form.

PRINT NAME: _____

SIGNATURE:_____ **DATE:** _____

PLEASE NOTE THAT ANY CHARGES INCURRED BY THE GENERATION OF ELECTRONIC PAYMENTS WILL NOT BE CHARGED TO THE CLIENT. ALL FEES STRICTLY RELATED TO THE PROCESSING OF ELECTRONIC PAYMENTS ARE THE SOLE RESPONSIBILITY OF THE HEALTH INSURANCE DEPARTMENT.