GOVERNMENT OF BERMUDA

Ministry of Health

Health Insurance Department

ELECTRONIC PAYMENT AGREEMENT

RETURN THIS FORM TO:
Health Insurance Department
Attention: Claims Settlement Section
PO Box HM 2160
Hamilton HM JX Bermuda

OR Fax to: (441) 295-9213
OR E-mail to: hip@gov.bm

Please complete all fields, printing or typing information clearly. Fields designated with asterisks ** are required.

Personnel	
**Organization Name:	
**Contact/Accounting Officer:	

Contact Details	
**E-mail:	
**Telephone (direct):	
Fax:	
Mailing Address (for Correspondence):	

Bank Details	
**Bank Name:	
**Account Name:	

Street Address – Sofia House, 2nd Floor, 48 Church Street, Hamilton HM 12
Mailing Address – PO Box HM 2160, Hamilton HM JX Bermuda
Phone: (441) 295-9210 Fax: (441) 295-9213 Email: hip@gov.bm Website: www.hip.gov.bm

**Account Number:	
**Swift Address:	
**Bank Address:	
Bank Clearing Details (if applicable):	
Payment Reference (if applicable):	

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.

****SIGNATURE: _____**

****DATE: _____**

****PRINTED NAME: _____**

TITLE: _____

(Mandatory Fields)**

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.