FIRST NATIONS HEALTH CONSORTIUM

DIRECT DEPOSIT ENROLMENT REQUEST

for Companies, Organizations, Individuals or Sole Proprietors

Department ☐

Please print clearly and complete all fields. Please keep the appropriate designate from First Nations Health Consortium informed of any change to your mailing address and/or banking information. A signature must be provided.

PART A - Identification Information

1 Legal name of Company, Organization, Sole Proprietor OR Individual

2 Social Insurance Number (SIN) for Individuals only

9 Digits – chiffres – ex. 123456789

A SIN is **NOT** required for client reimbursements. Check this box if applicable. ☐

Business/HST Number for companies, organizations and sole proprietors

9 Digits – chiffres – ex. 123456789

3 Remittance address, Street, Apt. No., R.R. or P.O. Box – Adresse de retour, Rue, No d'app., R.R. ou case postale

City, Town – Ville

Province

Postal Code
Code postal

4 Contact Telephone (with ext.)
N° de telephone (avec poste)

5 E-mail address – Adresse électronique **(Required for payment details/Requis pour les details de paiement)**

PART B - Banking Information

Complete Part B or attach a blank cheque with « VOID » written on it, if you do not have a void cheque, please see Part D on page 2 for acceptable alternatives.

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Branch No. - N° de la succursale

Institution No. - N° de l'institution

Account No. - N° de compte

Name(s) of account holder(s) - Nom(s), titulaire(s) du compte

Financial Institution Stamp – required if no void cheque is attached

The information provided is protected under The Privacy Act.

PART C - Consent

I, on my own behalf or as a properly authorized individual for this organization, in lieu of receiving a cheque, hereby authorize the issuance of future payments electronically to the banking information provided.

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Year Année | Month Mois | Day Jour

X

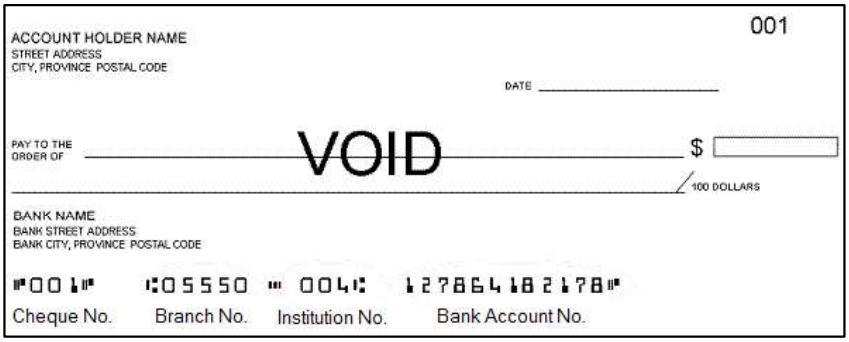
Signature of Applicant/Signature du (de la) requérant(e)

PART D - Instructions

PARTIE D - Instructions

Void Cheque Sample:

Échantillon de chèque nul:



Acceptable alternatives to a void cheque or stamped direct deposit form:

1. Account details that have been printed from an online banking site. (Please note some banks may only offer online fillable forms. These would only be accepted when stamped by the financial institution).
2. A letter from the bank or financial institution with bank account information.

WHERE TO SEND COMPLETED FORM:

a) Please forward this form by email to sarfaccount@abfnhc.com or by regular mail to:

First Nations Health Consortium
17015 - 105 Avenue
Edmonton, Alberta, T5S 1M5

Check box if you are a new client. ☐

FOR INTERNAL USE ONLY

HC-AB-_____

YYYY MM DD

Starting up

Within 2 business days of receipt of the completed Direct Deposit Enrollment Request Form by First Nations Health Consortium direct deposit will become the default payment method for all future payments. Please note: You may be contacted for additional information.

Need help with this form?

For information about direct deposit enrollment, please email sarfaccount@abfnhc.com.