COLINA

Colina Insurance Limited
P.O. Box N4728
Nassau, The Bahamas

ELECTRONIC FUNDS TRANSFER FORM
(for Primary Insureds or Members)

Date of Request

Day Month Year

Section A - Primary Insured or Member Information

Name of Primary Insured or Member

Member ID Number

Group Name (only applicable to group insurance)

Group Number (only applicable to group insurance)

Primary Insured or Member Address

No. / Street | City | State / Province / Island | P.O. Box

Telephone Numbers

Business | Cell | Fax

Email Address

Section B - Primary Insured or Member Banking Information

Name on Account (Beneficiary)

Bank/Branch

Bank Address

No. / Street | City | State / Province / Island | P.O. Box

Account Number

Account Type

☐ Savings
☐ Chequing

Section C - Declaration and Authorization

I HEREBY CERTIFY that the information stated above is true and correct and authorize Colina Insurance Limited to execute the Electronic Funds Transfer for reimbursement of benefits payable in accordance with my health plan's Schedule of Benefits. ☐ Yes ☐ No

Signature