DIRECT DEPOSIT (EFT) AUTHORIZATION FORM

This Agreement made
Between: _____(The Payee)

And: Vancouver Coastal Health Authority (the Payer)

Whereas the undersigned (the Payee) hereby authorizes The Payer to set up electronic funds transfer for all payment on account to the bank account as designated by The Payee in accordance with the banking information provided in this form.

The Payee will notify The Payer in writing of any changes in account information or termination of this authorization, at least five (5) business days prior to the next due date of the pre-authorized transfer of funds.

To have resident claims paid by EFT, the address information on the claims form provided by resident, must match the "permanent address information" provided below.

Payee Banking Information:

Payee Name: _____

Payee Employee ID #: _____

Bank Institution Name: _____

Bank Branch Number: _____

Bank Account Number: _____

Permanent Address: _____
(street address, city & postal code)

☐ **If you are requesting to update your current banking information, please check box.** ☐

Please also enclose an **ORIGINAL void cheque** for reference.
The Payer will issue a payment advice for each deposit to the Payee as a form of payment notification.

Email Notification Address: _____

_____
Authorized Signature (Payee)

Please return this form to the attention of: **Sandra Evans**
General Accounting Manager-Finance
3rd Fl – 590 West 8th Ave, Vancouver, BC V5Z 1C5