

BANK TRANSFER AUTHORIZATION FORM FOR CLAIM REIMBURSEMENT



1. POLICYHOLDER INFORMATION			
Full name	Last	First	M.I.
Policy number			DOB MM/DD/YY
Address			
E-mail address			
Work phone			Home phone
Cell phone			Fax
2. PREFERRED METHOD OF REIMBURSEMENT (PLEASE ✓)			
<input type="checkbox"/> Please transfer the reimbursement to my bank account in the USA			
<input type="checkbox"/> Please transfer the reimbursement to my bank account outside the USA			
3. BANK ACCOUNT INFORMATION			
Account holder			
Account number			<input type="checkbox"/> Checking <input type="checkbox"/> Savings
Beneficiary bank			
ABA number (ACH transfers)	(for banks in the USA only)	SWIFT code	(for banks outside the USA only)
Branch number			
Branch address			
FINAL ACCOUNT IF ANY			
Name			
Account number			
INTERMEDIARY BANK (PLEASE COMPLETE FOR TRANSFERS TO BENEFICIARY BANKS OUTSIDE THE USA)			
Name of bank			ABA number
SWIFT code			Other
Address			
Account number			
With my signature below, I agree to have all claim reimbursements transferred to the bank account indicated in this form, unless I inform Bupa and/or its affiliates in advance and in writing of any change in the account information provided herein.			
Policyholder's name (in BLOCK LETTERS)	Last	First	M.I.
Policyholder's signature			Date MM/DD/YY