

PROVIDER'S MASTER DATA FORM



GENERAL DETAILS : (* mandatory fields)			
Guarantee of Payment Number (if applicable)			
* Provider's Name			
* Tax Payer ID / EIN / VAT Number	* US Providers must attach W9 form	Tax Reporting Name	
* Full Address			
* Country		* Zip / Postal Code	
GENERAL CONTACT DETAILS (* mandatory fields)		REMITTANCE CONTACT DETAILS	
Contact Name			
Job Title			
Department			
* Phone Number			
* Email Address			
PRIMARY BANK DETAILS (* mandatory fields)		SECONDARY/INTERMEDIARY BANK DETAILS	
* Account / Beneficiary Name			
* Account Number / IBAN			
* Sort Code / SWIFT / BIC / Routing No			
* Bank Name			
Bank Number			
Branch Name			
Bank Country			

Authorization (Signature and Date Required)

_____ (Bank Account holder) hereby authorizes International SOS and/or its dedicated Agents to make payments of any benefits payable to us by crediting the payments to my account at the bank or financial institution named above. I agree to notify in writing of any change relating to the information provided on this form or of a withdrawal of this authorization.

Signature	Organization Name

Date	