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	

Once completed, please send it back to us using one the following email addresses, depending on where you are located:

Europe/Africa Regions: EMEA.provideradmin@internationalsos.com
Asia Pacific Regions: GSSAPAC.PNS@internationalsos.com
Latin American Regions: Mexico.Provider@internationalsos.com
North American Regions: phlganrequest@internationalsos.com