

PROVIDER'S MASTER DATA FORM



GENERAL DETAILS : (* mandatory fields)			
Guarantee of Payment Number (if applicable)			
* Provider's Name			
* Legal Entity 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 / Routing No / ABA			
* SWIFT / BIC			
* 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 / Middle East / North American Regions:	EMEA.provideradmin@internationalsos.com
Asia Pacific Regions:	GSSAPAC.PNS@internationalsos.com
Latin American Regions:	Mexico.Provider@internationalsos.com