

DIRECT DEPOSIT (EFT AUTHORIZATION FORM)

Would you like to Start EFT Change an existing EFT arrangement

This Agreement made between _____ and Accounts Payable, Provincial Health Services Authority (PHSA)
(the Payee)

| 1. PAYEE INFORMATION (MANDATORY) | | |
|------------------------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------------|
| Mailing Address _____ | | |
| Street Address | | City |
| Province | | Country |
| Postal Code | | |
| Note: For MSP#, GST#, and Employee # - if not applicable indicate so by selecting the N/A box. | | |
| MSP# _____ N/A <input type="checkbox"/> | GST# _____ N/A <input type="checkbox"/> | Employee # _____ N/A <input type="checkbox"/> |
| Accounting Contact Person _____ | | |
| Email _____ | | Telephone _____ |
| (For Remittance Statements) | | |
| *For validation purposes, please provide your previous address below. | | |
| If this section is not applicable to you please click here <input type="checkbox"/> | | |
| Mailing Address _____ | | |
| Street Address | | City |
| Province | | Country |
| Postal Code | | |

Please Note:

Payment Advice Notifications with attachments will be sent by email **ONLY**, no hard copies will follow. Please enable your computer to accept emails from FS84PRD@phsa.ca (Payor is PHSA) and FS84PRD@vch.ca (Payor is PHC or VCH).

| 2. STATEMENT OF AUTHORIZATION | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-----------------|
| By signing below, the Payee hereby authorizes PHSA to setup electronic funds transfer (EFT) for all payment on account to the bank account information submitted together with this form. The Payee will notify Accounts Payable in writing of any changes in account information or termination of this authorization, at least 10 business days prior to the next due day of the pre-authorized transfer of funds. | | |
| Name of Payee or Authorized Individual on behalf of Payee (Printed) | Signature of Payee or Authorized Individual on behalf of Payee | Date (DD/MM/YY) |
| | | |

| 3. SUBMISSION | |
|-------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> The Payee hereby agrees to send this completed form AND | |
| (i) a Void Cheque embossed with the account number and Payee's name OR | |
| (ii) a Validated Direct Deposit form from their Financial Institution to Accounts Payable in one of the following ways: | |
| via email PHSA payments: _phsa_finance_vendor@phsa.ca | via mail Accounts Payable 1795 Willingdon Avenue Burnaby, BC, V5C 6E3 |
| VCH/PHC payments: PHC-VCH-Vendors@phsa.ca | |

If you have any questions, please contact PHSA Accounts Payable Vendor Team (servicing PHSA, PHC, VCH) via telephone at 604.297.9248.

The personal information on this form is collected for the purpose of electronically transferring funds to your financial institution account. The personal information collected will be used and disclosed in compliance with Section 27 (2) of the British Columbia Freedom of Information and Protection of Privacy Act.

| Office Use Only | | | | |
|-----------------|--------------|-------------|---------------|---------------|
| Entered By | Date Entered | Reviewed By | Date Reviewed | ERP Vendor ID |
| | | | | |