# AUTHORITY TO ADD OR CHANGE PAYMENT DETAILS

**Please note** It is your responsibility to ensure all your bank and address details are kept up to date with nib.

**Use this form to advise nib health funds to pay benefits by Electronic Funds Transfer (EFT) to a nominated bank account.**

## PART 1 PROVIDER DETAILS

Provider name

Provider number

## PART 2 ACCOUNT DETAILS

X I authorise nib health funds to directly transfer payments via EFT into the account nominated below

Name of bank / financial institution

Address of bank / financial institution

BSB -

Account No.

Name on the Account

Do the above details relate to any additional provider numbers? Yes No

If yes, please list ALL additional provider numbers these bank details will apply to (if applicable)

Date this payment detail change/addition is to take effect: / /

## PART 3 AUTHORISATION

Contact phone number/s

**Providers signature**

**Date**

**Name**

**Title**

I hereby consent to nib health funds informing that I am an authorised representative of the provider.

**Need Help?** Call our Provider Relations Department on **1300 853 530**

email: **ProvRel@nib.com.au** fax **02 4925 1931**