

# ELECTRONIC FUNDS TRANSFER AUTHORIZATION

## FAS BENEFIT ADMINISTRATORS LTD. INTERIM FEDERAL HEALTH PROGRAM

In order to participate in EFT/ERS you must have Internet access to log on to the FAS website and the ERS.

<b>PROVIDER INFORMATION</b>		FAS Provider#:
Name: (Last)		(First)
Address: (Street)		
City:	Province:	Postal Code:
Change of Address (include written confirmation of change of address, including previous)		
Telephone Number: (      )		Fax Number: (      )
E-mail address:		

<b>BANK INFORMATION</b>		
Name of Bank:		
Address: (Street)		
City:	Province:	Postal Code:
Telephone Number: (      )	Fax Number: (      )	

**\*\*\*YOU MUST ATTACH A VOID CHEQUE\*\*\***

### AUTHORIZATION

Having signing authority for FAS Provider # \_\_\_\_\_ I authorize and direct FAS Benefit Administrators Ltd., as contracted for the Interim Federal Health Program, to have payment for my processed claims electronically deposited into the bank account described on the attached voided cheque. I understand that I can change this authorization by sending written notice to FAS Benefit Administrators Ltd.

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Name of Authorized Signature (*Please Print*)

\_\_\_\_\_  
Date

TOLL FREE: 1-800-770-2998

MAIL TO: IFH PROGRAM PRIORITY PROCESSING,  
FAS Benefit Administrators Ltd.  
9707 - 110 Street, SUITE 901  
Edmonton, AB T5K 2W8

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