BARBADOS SOCIAL SECURITY

FOR INTERNAL PURPOSES ONLY

Claim No. | | | | | | | | | | | | |

Direct Deposit Form

Please provide a copy of the header from your financial institution which bears the account number. The part of the statement which has the financial details of your account is not required.

PERSONAL DETAILS

FULL NAME OF CLAIMANT:

_____

_____

Name in full (Last Name, First Name, Middle Name) IN BLOCK CAPITALS

ADDRESS OF CLAIMANT:

_____

_____

Postal Code: BB | | | | | | |

National Insurance No. | | | | | | | | |

National Registration No. | | | | | | | – | | | | |

TAMIS No. | | | | | | | | | | | | | | |

E-mail Address: _____

Telephone No. __ __ __ – __ __ __ – __ __ __ __
Area Code

Cellular No. __ __ __ – __ __ __ – __ __ __ __
Area Code

FULL NAME OF ALTERNATE PAYEE:

_____

_____

Name in full (Last Name, First Name, Middle Name) IN BLOCK CAPITALS

ADDRESS OF ALTERNATE PAYEE:

_____

_____

Postal Code: BB | | | | | | |

National Insurance No. | | | | | | | | |

National Registration No. | | | | | | | – | | | | |

TAMIS No. | | | | | | | | | | | | | | |

E-mail Address: _____

Telephone No. __ __ __ – __ __ __ – __ __ __ __
Area Code

Cellular No. __ __ __ – __ __ __ – __ __ __ __
Area Code

Are you empowered to act on behalf of the claimant?

☐ Yes ☐ No If yes, please provide relevant documentation.

FINANCIAL INSTITUTION

Your benefit will be paid directly into your account therefore it is important that you provide **ALL** the information requested below. If you submit the form with incorrect information, payment of your benefit will be delayed.

Name(s) of Account Holder _____

FINANCIAL INSTITUTION	ACCOUNT NO.	NAME OF BRANCH (WHERE THE ACCOUNT WAS OPENED)	BRANCH / TRANSIT NO.

Please see overleaf

DECLARATION

Please read and sign below.

I have read and understand the information on this form. I declare that the information that I have provided on this form is correct.

DIRECTOR OF NATIONAL INSURANCE

I _____

Name in full (Last Name, First Name, Middle Name) IN BLOCK CAPITALS

of Address _____

_____

hereby authorize you to deposit my _____ payments to my/the account as stated overleaf.

(Type of Benefit)

Name (Print): _____

Signature: _____

Date: __ __ __ __ - __ __ - __ __

Year **Month** **Day**