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**PARTICULARS OF THE PAYEE**

Payee Name*	<input type="text"/>	Registration ID	<input type="text"/>
Entity Address*	<input type="text"/>		
City*	<input type="text"/>	ZIP*	<input type="text"/>
State	<input type="text"/>	PO Box	<input type="text"/>
Contact Person Name*	<input type="text"/>		
Phone*	<input type="text"/>	Email*	<input type="text"/>
For your claim submissions, what currency do you bill	<input type="checkbox"/> KYD	<input type="checkbox"/> USD	

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**PARTICULARS OF THE BANK**

Beneficiary Name*	<input type="text"/>		
Bank Name*	<input type="text"/>		
Bank Branch Address*	<input type="text"/>		
City*	<input type="text"/>	ZIP*	<input type="text"/>
Bank Account Number*	<input type="text"/>		
Account Type*	<input type="text"/>	Swift Code*	<input type="text"/>
Account Currency*	<input type="text"/>	IBAN/ABA Routing	<input type="text"/>
Other Currency	<input type="text"/>	ACH Number	<input type="text"/>

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I hereby declare that the particulars given above are true, accurate and complete and I authorise to receive electronic payments from One Health Cayman to the above bank account number and send the information to above email contact. If the fund transfer is delayed or lost because of incomplete or inaccurate information, we acknowledge that One Health Cayman will not have any liability for any loss or damage, direct or indirect, caused thereby.

Authorized Signatory	<input type="text"/>	Date	<input type="text"/>
Name	<input type="text"/>	Designation	<input type="text"/>
Email	<input type="text"/>	Mobile	<input type="text"/>