Scalable platform for global benefits

Direct deposit registration form

Fill out this form and send it to :

Email: support@segic.ca
Fax: 514-312-9047
Mail: Segic, 7220, Grande-Allée Blvd., Saint-Hubert, (Quebec) J3Y 0N8

IMPORTANT
All fields are requiered.

Type de demande	☐ **First registration**	☐ Edit contact personn
☐ Edit direct deposit	☐ Edit UIN	☐ Edit online statement
☐ Edit contact information (address, telephon, email, fax...)		☐ Add/Remove dental office

Identity of the requesting dentist					
Dentist first and last name					
Unique identifier number		Speciality			
Address					
City		Province		Postal Code	
Telephone		Fax			
Primary Email address					
Contact person		Title			
Preferred communication method	☐ Email	☐ Telephone	Language	○ French	◉ English
	☐ Fax	☐ Mail			

Banking information		
Branch or transit number	Institution number	Account number
Telephone number	Date when Segic can activate the link to your account	

Please list below the details for each dental office in which you practice and indicate whether you wish to receive payment of claims in your bank account or in the dental office listed.

Name of dental office № 1			Dental office ID	
Address				
City		Province	Postal Code	
Telephone		Email		
Payment to the dental office	Yes ◉ No ○	Add/Remove	Add ○	Remove ◉

Name of dental office № 2			Dental office ID	
Address				
City		Province	Postal Code	
Telephone		Email		
Payment to the dental office	Yes ○ No ○	Add/Remove	Add ○	Remove ○

Name of dental office № 3			Dental office ID	
Address				
City		Province	Postal Code	
Telephone		Email		
Payment to the dental office	Yes ○ No ○	Add/Remove	Add ○	Remove ○

Name of dental office № 4			Dental office ID	
Address				
City		Province	Postal Code	
Telephone		Email		
Payment to the dental office	Yes ○ No ○	Add/Remove	Add ○	Remove ○

Name of dental office № 5			Dental office ID	
Address				
City		Province	Postal Code	
Telephone		Email		
Payment to the dental office	Yes ○ No ○	Add/Remove	Add ○	Remove ○

I, the undersigned, declare that I am authorized to complete this form on behalf of the requesting dentist. I hereby authorize SEGIC to make direct deposits for reimbursement of fees and services incurred, into the bank account information specified in the direct deposit section on the first page of the form. These instructions supersede all previous instructions regarding direct deposit payment of claims. I also agree to reimburse SEGIC for any funds mistakenly deposited into this account. This authorization remains in effect until further notice.

First and last name of the dentist	Unique identifier number	Signature

Include the cheque specimen marked “Void” here

The following information must appear on the specimen cheque:

- Business or commercial name
- Address
- Account number

If the specimen cheque does not include this information, please forward a letter from your financial institution confirming the name of the account holder, your account number and the name(s) of the signing authority or authorities.

Registration for online statements

IMPORTANT

All fields are required (if the dentist's contact information is the same as on the direct deposit enrollment form, you do not need to complete the "Dentist" section).

Applicant			
Last name		First name	
Telephone		Fax	
Email			

Dentist					
First and last name					
Unique identifier number		Speciality			
Address					
City		Province		Postal Code	

If you have any questions, please contact us at 514-312-9046 or by email at support@segic.ca