

AUTO – CREDIT ARRANGEMENT FORM

Please submit accomplished form to glapiproviderrelations@generali.com.ph. Rest assured that all information obtained shall be kept confidential and shall be used by GLAPI for the purpose of facilitating faster payments of its accredited providers.



RELATION WITH GENERALI: ___ACCREDITED DOCTOR ___ACCREDITED HOSPITAL / CLINIC PROVIDER

FULL NAME OF DOCTOR / HOSPITAL / CLINIC: _____

EMAIL ADDRESS: _____

CONTACT NUMBER: _____

TIN: _____

ACCOUNT NAME: _____

ACCOUNT NUMBER: _____

BANK NAME: _____

BANK LOCATION: _____

TYPE OF ACCOUNT: ___ Savings ___ Current ___ Others (please specify): _____