Pula
Medical Aid Fund

DEBIT ORDER INSTRUCTION

Please complete the following in BLOCK LETTERS

Title: Name: Surname:

ID/Passport Number: Res Address:

Postal Address: Telephone:

Email address: Cellphone:

Direct Debit Authorisation

I, (name) …… (surname)……hereby authorise **Pula Medical Aid Fund/Administrator** to draw against my account with the below-mentioned bank (or any other branch or bank to which I may transfer my account)**,** the sum of P being the monthly contribution due on the day of each month commencing on

Declaration

1. All such withdrawals from my account by you shall be treated as though they have been signed by the authorised account holder.
2. I agree to pay any bank charges relating to this debit order instruction. In the event that the debit order is unpaid for whatsoever reason, I agree to reimburse Pula Medical Aid Fund charges levied by the bank.
3. This authority may be cancelled by giving you one-month notice by writing. I shall not be entitled to any refund of amounts which you have already withdrawn while this authority was in force if such amounts were legally owing to you.
4. I confirm this account is compliant with the Banking Act or any Regulatory act.

Banking Details:

Account Name:

Bank name: Branch number:

Account number: Branch name:

Type of Account: Current Savings Other (specify)…….

Signed at ..... on this ..... day of……..20.....

Authorised Signatory: .....

Membership number: