

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

- All such withdrawals from my account by you shall be treated as though they have been signed by the authorised account holder.
- 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.
- 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 I shall not be entitled to any refund of amounts which you have already withdrawn while this authority was in force if such amounts were legally owing to you.
- 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 of20.....

Authorised Signatory:

Membership number: