DEBIT ORDER MANDATE

Selfmed
MEDICAL SCHEME

Tel: 0860 787 372
Fax: 0860 288 363
Selfmed Medical Scheme
PO Box 5543
Tygervalley 7536
Reg. No: 1446

- Use only black ink.
- Use block capital letters to fill in the spaces.
- Use only one character per block.
- Leave one block empty between words.
- Where necessary, mark square clearly with an X.

A DETAILS OF MEMBER

Name

Surname

Membership number

ID number

B BANK ACCOUNT DETAILS FOR THE DEDUCTION OF MONTHLY CONTRIBUTION (BY DEBIT ORDER)

Account holders name

Physical address

Area code

Name of bank/building society

Branch

Branch code

Type of account ☐ Savings account ☐ Cheque account ☐ Transmission account

*FNB does not allow debits against certain savings accounts. Please check with your bank.

Account number

Deduction date D D M M Y Y Y Y Deduction amount

I/We hereby authorise Selfmed Medical Scheme (SELFMED) to issue and deliver payment instruction for collection against my/our above mentioned account at my/our above mentioned bank (or any other bank or branch to which I/we may transfer our account) on condition that the sum of such payment instruction will never exceed my/our obligation as agreed to in the Agreement and commencing on D D M M Y Y Y Y and continuing until this Authority and Mandate is terminated by me/us by giving Selfmed Medical Scheme notice in writing of not less than one month, and sent by prepaid registered post or delivered to Selfmed Medical Scheme address as indicated below.

I/We understand that the withdrawals hereby authorised will be processed through a computerised system provided by the South African Banks. I/We also understand that details of each withdrawal will be printed on my/our bank statement. Such must contain a number which must be included in the said payment instruction and provided to me/us to enable me/us to identify the Agreement.

This number must be added to this form before the issuing of any payment instruction.

I/We acknowledge that all payment instructions issued by Selfmed Medical Scheme shall be treated by my/our above mentioned bank as if the instructions have been issued by me/us personally.

I/We agree that though this Authority and Mandate may be cancelled by me/us, such cancellation will not cancel the Agreement. I/We shall not be entitled to any refund of amounts which Selfmed Medical Scheme have withdrawn while this Authority was in force, if such amounts were legally owing to Selfmed Medical Scheme.

I/We acknowledge that this Authority may be ceded or assigned to a third party if the Agreement is also ceded or assigned to that third party, but in the absence of such assignment of the Agreement, this Authority and Mandate cannot be assigned to a third party.

In illustration, an example of the Agreement Reference Number that will enable the contribution payer to identify the Agreement payment, is as follows:
SELFMED 49000368725 - The Agreement Reference Number will be communicated to the contribution payer upon registration and issue of membership number.

All enquiries to be referred to:

Selfmed Medical Scheme
South Gate Office Park
First Floor South
Carl Cronje Drive
Southgate
Tyger Waterfront
Bellville
7530

021 943 2300
expert@selfmed.co.za

Account holders signature _____ Account holders name _____ Date D D M M Y Y Y Y