DEBIT ORDER AUTHORISATION

transmed MEDICAL FUND

Request to arrange payment of medical aid contributions by debit order.

Medical aid number

1. First name(s)
2. Surname
3. Telephone number C O D E Fax number C O D E
4. Cellular number 5. ID no.
6. E-mail address
7. Addresses

Postal address

Postal code

8. Banking details

Details required	
Name of account holder	
Name of bank	
8-digit branch code	
Branch	
Account number	
Type of account Cheque/Transmission/Savings	

Contribution amount R ,

Date of first deduction (1st of month) D D M M Y Y

I authorise Transmed to draw from my bank/building society account (wherever it may be), the premiums (and any short payments or claims debt) due in terms of the Rules of the Fund, without prejudice to the rights of Transmed. I further authorise Transmed to increase the amounts due to it in terms of the Rules of the Fund from time to time and authorise my bank/building society to effect payment of such increased amount upon receipt of a written notice from Transmed stating the increased amount and the date from which it is payable. This authorisation is to remain in force until I cancel it by giving written notice to Transmed as required in terms of the Rules. I agree that I am not entitled to recover any amount drawn from my account by means of this debit order and that should my bank/building society repay such amount to me, I will refund it immediately to Transmed. I undertake to notify Transmed immediately of any change in respect of my address or bank/building society. I acknowledge that the party hereby authorised to effect the drawing(s) against my account may not cede or assign any of its rights to any third party without my prior written consent and that I may not delegate any of my obligations in terms of this contract/authority to any third party without prior written consent of the authorised party.

Name of account holder | Signature of account holder | Date D D M M Y Y

for all our people