DEBIT ORDER FORM

Your Banker's Name and Branch

.....

.....

Your Bank Account No.

Account Holder's Name

Account Type (savings can not be debited)

Bank/Branch sort code

Postal Address

Main Member Surname

Main Member First name

Date of Birth d d - m m - y y y y

Omang/passport No.

Membership Number

Membership Start Date 01 mm /20 y y

Email Address

@

Telephone

(w) **(h)** **(mobile)**

Mandate to your Bank

Please pay **Botsogo Health Plan** Direct Debit for the account detailed in this mandate subject to the safeguards assured by the Direct Debit guarantee. I understand that this mandate may remain with **Botsogo Health Plan** and details shall be passed electronically to my Bank.

Authority to Debit my Account

By signing this form I have given authority to my bankers to debit my account using Direct Debit option towards my bill settlement with **Botsogo Health Plan or any variances that may result in changes in membership or subscription rates. A covering authorizing letter (on letterhead) is required if payment is from a company account.**

Debit my account monthly based on instructions by Botsogo Health Plan Effective Debit Date dd / mm/ yyyy

Debit my account monthly with **P** ,

Monthly Debit Date (tick appropriately) 26th 28th 30th 2nd

Amount in words.....

.....

Please tick to authorize Botsogo Health Plan to renew your debit order annually and make adjustments with changes to your membership automatically. Renewal Adjustments

.....
Authorised Signatory

Date.....

.....
Authorised Signatory

Date.....