

DEBIT ORDER AUTHORISATION

REQUEST TO ARRANGE PAYMENT OF MEDICAL AID CONTRIBUTIONS BY DEBIT ORDER.

PLEASE COMPLETE IN BLOCK LETTERS.

It is imperative that all sections of this form be completed in full. Failing to do so will cause a delay in the processing of the request, as the incomplete form will be returned to the applicant.

Once the form has been completed, it should be returned to membership@imperialmotusmed.co.za.

If you require assistance in completing this form, please call 0860 467 374.

1. MEMBER INFORMATION

Member number	<input type="text"/>	Title	<input type="text"/>
Surname	<input type="text"/>		
First name(s)	<input type="text"/>	Initials	<input type="text"/>
Identity/Passport number	<input type="text"/>		
Telephone numbers	<input type="text"/> Work	Home	<input type="text"/>
	<input type="text"/> Cell number		
Email address	<input type="text"/>		
Physical address	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/> Code <input type="text"/>		

2. BANKING DETAILS

Please attach a copy of your ID and a bank statement or a stamped letter from your bank (not older than three months).

Name of account holder	<input type="text"/>		
Account number	<input type="text"/>		
Name of bank	<input type="text"/>		
Branch name	<input type="text"/>		
Eight-digit branch code	<input type="text"/>		
Account type	<input type="checkbox"/> Current	<input type="checkbox"/> Savings	<input type="checkbox"/> Transmission <input type="checkbox"/> Cheque
Contribution amount	<input type="text"/> R		
Date of first deduction	_____ (1st of the month)		
	DD/MM/YYYY		

