FIRST MUTUAL
HEALTH
Go Beyond

DEBIT ORDER AUTHORISATION FORM

I the undersigned authorize and request First Mutual Health Company, until cancelled by me in writing to draw against my bank account on its debit order system the amounts indicated below:

BANK ACCOUNT DETAILS

Name of
Bank……..

Branch
Name……

Address……
…

Account holder's Surname…….

First Name (s)
……..

Payer's Surname (If different from account Holder)……..

Firsts Name (s)……

Bank Account Number……..Current/Savings Account

CONTRIBUTION DETAILS

The total to be deducted is USD$ ……with effect from the

……day of……..20 ……..and is also applied as follows:

FIRM NUMBER	CONTRIBUTION

DATE……SIGNATURE…….

Please note: If the payer is a company, the authorized person (indicating designation) must sign over the Company stamp.