Namibia Medical Care
P.O. Box 24792
Windhoek, Namibia
Tel. (061) 287 6040
Fax (061) 287 6059

DEBIT ORDER

I/We, the undersigned, request Namibia Medical Care to arrange with my/our bank and Multi-Data for the premiums/balance premiums payable in terms of the conditions of the membership (as they may be amended from time to time) to be drawn against my/our bank account (wherever it may be) in accordance with the debit order system.

First Collection Date D D M M Y Y

Membership No.

Premium (N$) Payable in Advance Monthly

Account Name (name displayed on the bank account from which the premium is to be collected):
If it is a company's or institution's account, state

Account Name

If it is an individual's account, state:

Surname Initials

Date of Birth D D M M Y Y ID/Passport No. (Payer)

Address (Payer):

Is the Principal Member also the Payer? Yes No

Principal Member's Name (if not Payer)

Surname

First Name Initials

Date of Birth D D M M Y Y

Bank Name

Branch Name

Branch Code Payer's Bank Account No.

Type of Account Current Savings

Signature of Payer Date D D M M Y Y

(If Payer is a company, the form must be stamped by an authorised official)

For Bank Use	Confirmation of account name (the name displayed on the bank account from which the premium is to be collected)	BANK STAMP

For Office Use

Particulars of cash payments, with debit order (specify membership number(s), amounts, dates and cash statements)