**Namibia Medical Care**
**P.O. Box 24792**
**Windhoek, Namibia**
**Tel. (061) 287 6040**
**Fax (061) 287 6059**
**Email: FinReception@methealth.com.na**

# 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)