7 Lutman Street, Richmond Hill, Port Elizabeth, 6001
P.O. Box 1672, Port Elizabeth, 6000
Customer Care: 0860 08 08 88 or 041 395 4545
Email: suremed@providence.co.za
website: www.suremedhealth.co.za

REQUEST FOR PAYMENT BY DEBIT ORDER

Surname: …….

Membership no: ……..……...

Postal address: ……...

……..……

……...

Tel no: ( ) ……. Cell no: ……..……...

Bank: …… Branch code: ……..…….

Account holder / Account name: ……

Account number: ……

Account type: ❑ **Cheque/Current** ❑ **Transmission** ❑ **Savings**

Please attach a copy of a cancelled cheque or bank date stamp as confirmation of banking details.

Bank Date Stamp

I hereby give permission to debit my account for medical contributions:
I hereby give permission to debit my account for Gap cover contributions:
I hereby give permission to use this account for all claim refunds:

……
Authorised Signature

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I hereby request Electronic services to draw against my bank account by automatic debit order in accordance with the ACB system, a sum equal to the amount due by me in respect of medical aid contributions and Gap cover for which I am liable.

I understand that I can terminate this arrangement by written notification at any time, but that this termination will have no effect on withdrawals already made by the Bank.

Signed by …… on this …… day of ……20…..

Please email the completed form to suremedmembership@providence.co.za or fax to (041) 3954588.