OLDMUTUAL

DEBIT ORDER AUTHORITY

IF YOU WISH TO PAY YOUR INSURANCE PREMIUMS MONTHLY, PLEASE COMPLETE THIS FORM

Policy Number/s:

INDIVIDUAL IN WHOSE NAME THE POLICY IS HELD

Surname and initials:

Previous names, if any:

Title and First Names:

ID/Passport number: Date of Birth: D D M M C C Y Y

CONTACT INFORMATION

Tel. (Code) (Home) (Code) (Work)

Fax: (Code) (Fax) Cellphone

E-mail address:

BANK DETAILS

Surname of account holder: Initials:

Bank and Branch:

Branch code: Account number:

Account type: Current Savings Cheque

Signature of Payer: _____ Date: D D M M C C Y Y

NB: The banking details for the policy number(s) specified in this form will be amended in accordance with this request.