

Glenrand M.I.B.
288 Kent Road
Ferndale Randburg 2194
P O Box 2544 Randburg 2125



Medico Legal Helpline 0800 114747
e-mail:kallanson@glenrandmib.co.za
VAT Reg No 4360166401

(FAX TO : 011-782-070)

METHODS OF PAYMENT

Attention: XANA

(Please select as appropriate and fax this form to us and post the original.
 Your Certificate of Insurance will be issued on receipt of this form.)

I wish to pay my subscription in accordance with the following instructions:

CHEQUE	
Crossed and made payable to: GLENRAND MIB MEDICAL MALPRACTICE	R.....

OR

DIRECT DEPOSIT	
(Kindly deposit the premium directly into our bank account - details hereunder and fax a copy of the deposit slip, on which your name is clearly printed, to us)	
Glenrand M.I.B Professional Services / Nedbank Corporate Client Services Account No 1454006951 / Branch code 145405	Internet branch code 19840500 R.....

OR

DEBIT ORDER AUTHORITY		
Monthly Direct Debit - Please charge instalments to my bank account collected consecutively on or just after the 1st working day of the month. In favour of: GLENRAND MIB MEDICAL MALPRACTICE		
ISSUED BY:	Full names and Surname..... Postal address..... Code.....	
I hereby record that I have applied to GLENRAND MEDICAL MALPRACTICE for Medical Malpractice Indemnity and that I wish to pay my premium by way of a debit order.		
I hereby request and authorise GLENRAND MEDICAL MALPRACTICE to draw against my account with the bank indicated below (or any bank or branch to which I may transfer my account) the amount necessary for payment of my annual premium to GLENRAND MEDICAL MALPRACTICE on the understanding that this will be drawn against my account. I hereby request and authorise GLENRAND MEDICAL MALPRACTICE to arrange with my bank for the payments accordingly.		
I agree to pay all bank charges in connection with this instruction and agree that this authority will remain in force for as long as premium is owed to GLENRAND MEDICAL MALPRACTICE. In the event of my Medical Malpractice Insurance being terminated, then, upon confirmation by GLENRAND MEDICAL MALPRACTICE, this authority will terminate likewise. I further agree that receipt of this instruction by GLENRAND MEDICAL MALPRACTICE shall be regarded as receipt thereof by my bank and understand that the payments hereto authorised will be processed by the bank electronically and that details of each payment will appear on my bank statement or on an accompanying voucher.		
I confirm that the details provided in the authority are correct in all respects. I confirm that I will notify GLENRAND MEDICAL MALPRACTICE in writing of any change in the bank details provided below at least one calendar month prior to such change.		
BANK DETAILS		
Account Name	Title	Name and Initials
Bank	Branch	Current Acc.
Branch code	Account no.	Trans Acc.
IMPORTANT: PLEASE ADVISE US IMMEDIATELY OF ANY CHANGE IN THE ABOVE DETAIL!		
Signed at on this day of 20		
ID No. Signature		
Name Capacity		

EFFECTIVE DATE	LIMIT OF INDEMNITY
----------------------	--------------------------