DEBIT ORDER AUTHORISATION FORM FOR INDIVIDUALS

MEMBER INFORMATION

NAME & SURNAME	
ID NUMBER	
POLICY NUMBER	

BANKING DETAILS

ACCOUNT HOLDER'S NAME		BANK / BUILDING SOCIETY		
ACCOUNT NUMBER		BRANCH		
BRANCH CODE		ACCOUNT TYPE		CURRENT
				TRANSMISSION
				SAVINGS

PLEASE SELECT PREFERRED DEBIT ORDER COLLECTION DATE

1ST	15TH	25TH	31ST

*Please note that premiums are collected in advance on your selected debit order date indicated above.

Please include a bank account verification letter or bank statement not older than (3) three months, a copy of the account holder's ID and proof of address not older than three (3) months. Send the signed form and attachments to membership@unityhealth.co.za.

In respect of this Unity Health policy, I hereby authorise the insurer or its representatives to debit this account with an amount based on the premium rates under the selected plan type. Such authorisation shall remain valid and in effect until canceled in writing with one (1) calender months' notice. I further authorise the insurer to increase the amount due in terms of the policy and authorise my bank to effect payment on the relevant increases. Notwithstanding the fact that I grant the insurer permission to collect premiums, I acknowledge that it is my responsibility to ensure that premiums are collected for the policy to remain active and the benefits to remain in effect.

ACCOUNT HOLDER'S SIGNATURE	PRINT NAME	DATE OF SIGNATURE
EFFECTIVE DATE (date debit order should commence)	DD/MM/YY	

USE OF PERSONAL INFORMATION DECLARATION

I hereby consent to Unity Health processing my personal information, including but not limited to, the administrative functions listed below.

- Processing this application;
- Processing of future instructions submitted;
- Communications with me in relation to any matters in relation to my policy.

I consent to Unity Health disclosing and transferring my personal information to any contracted third party for the purposes of collecting premiums, claim assessments and statutory reporting in connection with this contract.

I acknowledge I have the right to:

- Object to the processing of my personal information on reasonable grounds unless legislation allows for such processing, in the manner prescribed by the POPI Act;
- Lodge a complaint with the Information Regulator;
- Request from Unity Health details of any of my personal information Unity Health holds on my behalf and details of how my personal information has been processed.

Unity Health will use its best endeavors to ensure your personal information is reliable, however it remains your responsibility to advise Unity Health of any changes to your personal information in a timely manner. The information supplied to Unity Health must be complete, correct and up to date.

I understand why my personal information is required and the purpose it will be used for, and I hereby give Unity Health consent to process my personal information as provided above.

Please return completed form and supporting documentation to Unity Health

Unity Health
PO Box 1862, Cramerview, 2060
Tel Number: 0861 366 006
E-mail Address: membership@unityhealth.co.za