DEBIT ORDER AUTHORITY

THE INSURED / NAME OF POLICY: _____

Account Holder / Name: _____

Policy Premium Paying Bank: _____

Name of Financial Institution: _____

Branch Name and Town: _____

Account Number: _____(not card number)

Branch Code: _____

Type of Account: _____ (eg Current / Saving / etc)

Abbreviated Name: DELPHISURE

Authority is hereby granted to draw against my/our account when due to premium(s) for all policies. It is further understood and agreed that if any premium(s) is/are not paid, the policy(ies) are cancelled automatically from the end of the period of insurance for which premium has been paid. In addition this authority is effective against any party collecting funds for insurance purposes as authorized by Delphisure. Should my/our account be transferred, this authority is also effective against such alternative account. Policy conditions are to apply. Our premiums on debits may vary to reflect any change in cover, risk, sum insured or policy rates and policy fees. All debits from my/our account are to be treated as each signed personally and this instruction is to be regarded as received by my bankers (whichever they may be).

NOTE

DISCLOSURE OF INFORMATION (POPIA ACT)

We may disclose your personal information to our service providers who are involved in the delivery of products or services to you. We have agreements in place to ensure that they comply with these privacy terms.

We may share your personal information with:

- Third parties for the purposes listed above, for example credit reference and fraud prevention agencies, law enforcement agencies.
- Other insurers to prevent fraudulent claims.
- Other companies/entities in the Old Mutual Insure Group and, where appropriate, Old Mutual Insure sponsored retirement funds, for the purposes listed above, or when we believe it will enhance the services and products we can offer to you , but only where you have not objected to such sharing.
- Other third parties from whom you have chosen to receive marketing information.

CONFLICT OF INTEREST

If you believe there is any conflict of interest in relation to your insurance activities, please advise. Equally we shall advise you in writing if we believe any conflict applicable. A copy of our conflict of interest management policy is available at your request.

COMPLAINTS PROCESS

If you would like to lodge a complaint regarding the service that you have received please contact your insurance broker and failing a satisfactory result please contact your insurer. If you wish to proceed with a complaint, please contact us and a detailed documented outline is to be provided to assist you with such processes.

CONFIRMATION OF AUTHORIZATION

I/We declare all the above statements in this proposal to be true and correct and further are duly authorized to execute these documents/statements, which are binding on all parties.

THIS DONE AND EXECUTED AT ..... ON ...../...../.....
[PLACE] [DAY] [MONTH] [YEAR]

Bank Account authorized signature: _____

Signature Witness 1: _____

Signature Witness 2: _____