

STOP ORDER FORM PLEASE TAKE THIS FORM TO YOUR BANK

Donor Name:

Address:
.....
.....

Tel (h): Fax:

Tel(w):

ACCOUNT DETAILS

Name of Account Holder:.....

Your ID:

Bank:

Branch name & Town:

Branch No.

Account Number:

Serial Number

Account Type

Current

Savings

Transmission

Cheque

Please draw against my above mentioned account held by the above mentioned bank (or any other bank or branch to which I may transfer my account) the sum of: R

Once Off

Regular

If regular, please debit my account with the same amount (please circle time period):

weekly / monthly / quarterly / annually from the initial payment.

Do you wish payments to continue until you tell us to stop?

Yes

No

Expiry date: (YYYY/MM/DD)

All such withdrawals from my bank account by you shall be treated as though I had signed them personally. I understand that the withdrawals hereby authorised will be processed through a system known as ACB Magnetic Tape. I also understand that the details of each withdrawal will be printed on my bank statement.

I agree to pay any bank charges relating to this debit order instruction:

Yes

No

THE bank details for the TAC

Treatment Action Campaign
Nedbank
Jorissen St, Braamfontein Branch
Account No: 128 405 1870
Branch Code: 195 005

This authority may be cancelled by me by giving you thirty days notice in writing, sent by prepaid registered post, but I understand that I shall not be entitled to any refund of amounts that you have withdrawn while this authority was in force if such amounts were legally owing to you. Receipt of this instruction by you shall be regarded as receipt thereof by my bank whichever it is or will be. I agree that if there is not enough money in my account, the payment will not be made and I may have to pay a fee.

Signed aton this.....day of
..... in the year

Signature as used for signing cheques

The signature of your parent or guardian (if you are under 18 years old)

.....

DATE (YYYY/MM/DD)