

CLOSURE / CANCELLATION REQUEST

SUBMISSION DETAILS:	FAX: 086 691 3665 / 011 801 2082	EMAIL: info@healthcard.co.za
----------------------------	---	--

MEMBER NAME:		DATE REQUESTED:	
HEALTHCARD / ID NUMBER		EFFECTIVE DATE OF AMENDMENT:	
REASON FOR CLOSURE:			

Principle Account Holder's banking details for transfer of available balance:

BANK NAME:		BRANCH NAME:	
ACCOUNT TYPE:		BRANCH CODE:	
NAME OF ACCOUNT HOLDER:		ACCOUNT NUMBER:	

ACCOUNT HOLDER SIGNATURE:	
----------------------------------	--

Please note:

Debit order cancellation notice must be given 5 working days prior to due debit order collection date.