



Doc no:	
Acc no:	
Order no:	
Credit Approved:	

Call Center: 086 078 3466 ■ Tel: +27 11 923 9548 ■ Fax: +27 11 923 9420 ■ Address: 110 Loper Str, Aeroport, Spartan Ext 2
 Branch Name: Date: STEINMED Representative:

HCRW AD-HOC <input type="checkbox"/> PURCHASE PRODUCTS <input type="checkbox"/> SERVICE CONTRACT <input type="checkbox"/> CONVERSION <input type="checkbox"/> RESIGN <input type="checkbox"/>	
BUSINESS NAME:	PRACTICE NO:
REG NO:	VAT NO:
TELEPHONE:	FAX:
BILLING ADDRESS:	SERVICE ADDRESS:
CONTACT NAME:	E-MAIL:
BUSINESS TYPE: (PTY)Ltd <input type="checkbox"/> SOLE OWNER <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> CC <input type="checkbox"/> PROFFESION (Please Specify)	
LANDLORD NAME:	ACCOUNTS CONTACT:
LANDLORD TEL:	ACCOUNTS E-MAIL:
OWNER / DIRECTORS / MEMBERS:	
NAME:	ID NO:
NAME:	ID NO:
NAME:	ID NO:
TRADE REFERENCES:	
NAME:	ACC NO: TEL:
NAME:	ACC NO: TEL:
ASSET VALUE: < R1 000 000 <input type="checkbox"/> > R1 000 000 <input type="checkbox"/> ANNUAL REVENUE: < R1 000 000 <input type="checkbox"/> > R 1 000 000 <input type="checkbox"/>	
I, We the undersigned, by my/our signature hereto, warrant that the asset and turnover values as declared above are true and correct and that no material facts that would be relevant in terms of the National Credit Act no.34 of 2005 has been omitted.	

PRODUCT DESCRIPTION	SERVICE FREQ.	QTY	PRICE EXCL. VAT	COMMENTS

PAYMENT METHOD:
 DEBIT ORDER EFT DIRECT DEPOSIT

SUB TOTAL	
VAT	
TOTAL	

BANK DETAILS AND DEBIT ORDER AUTHORISATION

I / We hereby authorize SteinMed to draw against my/our bank account by direct debit order the amount which may be due from time to time in terms of this agreement and the schedule of products and services annexed hereto as schedule 1. I / We hereby authorise the bank to pay and debit my/our account with all such debited drawn by SteinMed.

I / We understand that either I / We or SteinMed can terminate this request by written notification to the other party at any time, but that the termination will have no effect on any withdrawals already made by the bank and credited to SteinMed. I / We undertake to advise SteinMed in writing of any changes in the bank details of my/our account.

Name of Bank: Branch:

Branch Code: Account No:

Account Name:

Acc Type: Cheque Savings Transmission

Signed at this the Day of 200

THE CUSTOMER WARRANTS THAT THE INFORMATION GIVEN ABOVE IS TRUE AND CORRECT IN ALL RESPECTS AND THAT NO MATERIAL FACTS HAVE BEEN OMITTED WHICH MAY ADVERSELY AFFECT STEINMED AND FURTHER WARRANTS AND ACKNOWLEDGES THAT ALL TRANSACTIONS CONCLUDED WITH STEINMED WILL BE SUBJECT TO STEINMED'S TERMS AND CONDITIONS ATTACHED HERETO WHICH THE CUSTOMER ACKNOWLEDGES HAVING READ AND AGREES TO BE BOUND.

Signed at this the Day of 200

Before the undersigned witness.

Name & ID of Signatory: As witness:

Designation: STEINMED Representative:

Signature:

For and on behalf of the Applicant, being duly authorized hereto