SEPA DIRECT DEBIT MANDATE (Ireland)

TITLE	POLICYHOLDER(S) NAME (PLEASE INDICATE BOTH NAMES IF JOINT POLICYHOLDERS)
ADDRESS	(PLEASE INDICALE BOTH NAMES IF JUINT POLICTHOLDERS)
	POSTCODE
If this application is on behalf of a	company please provide:
CONTACT NAME:	NAME OF COMPANY:
	Policy number:
Please indicate your preferre	
1st Would you prefer to make y	8th 15th 22nd your payment:
monthly and	nually
0ED4 D: + D 1 : M	
SEPA Direct Debit Man	
	n BLOCK CAPITALS using BLACK INK.
Unique Mandate R	
	te form, you authorise Hiscox SA to send instructions to your bank to debit your account and (B) your count in accordance with the instruction from Hiscox SA .
As part of your rights,	you are entitled to a refund from your bank under the terms and conditions of your agreement with your
	be claimed within 8 weeks starting from the date on which your account was debited. Your rights are ent that you can obtain from your bank
Nama	<cli><cli>name></cli></cli>
Name	• Client name>
Address	<cli><cli>address></cli></cli>
	<cli><cli>ent postcode></cli></cli>
IDANI	
IBAN	Illernational Bank Account Number)
BIC	
ыс	(Bank Identifier code)
PLEASE RETURN	то
Name of Creditor	Hiscox SA
Creditor Identifier	FR57ZZZ453429
Creditor Address	The Observatory, 7-11 Sir John Rogerson's Quay
	Dublin 2, D02 VC42
	REPUBLIC OF IRELAND
Type of Payment	■ Recurrent <u>×</u>
Date of Signing	•
Signature(s)	Please sign here