

MEDICAL CASH PLAN

HIVE INSURANCE SERVICES

SEPA DIRECT DEBIT MANDATE



Unique Mandate Reference:

Creditor Identifier: **IE79API303578**

Legal text: By signing this mandate form, you authorise

- a) Hive Insurance Services DAC to send instructions to your bank to debit your account and
- b) your bank to debit your account in accordance with the instruction from Hive Insurance Services DAC.

As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited. Your rights are explained in a statement that you can obtain from your bank.

Please complete all the fields below

Name:

Address:

Eircode:

County:

IBAN (International Bank Account Number):

Swift BIC:

Hive Insurance Services DAC, Suite 211, 3013 Lake Drive, Citywest Business Campus, Dublin 24.

Type of payment is recurrent/repeated

Date of signing:

Signature(s):

Please return this mandate to:

Hive Insurance Services DAC, Suite 211, 3013 Lake Drive, Citywest Business Campus, Dublin 24.

Person on whose behalf payment is made:

(Name of policyholder, if different to above)