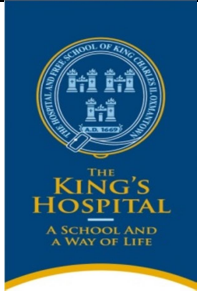


Please complete all fields below to instruct your bank to make payments directly from your account.
Return the completed form to **The King's Hospital**.

SEPA DIRECT DEBIT MANDATE		
Unique Mandate Reference (KH reference only)		
Creditor Identifier	IE59ZZZ301028	THE KING'S HOSPITAL

ACCOUNT HOLDER NAME _____

ADDRESS _____

PUPIL(S) NAME(S) _____

ACCOUNT NUMBER (IBAN) _____

SWIFT / BIC _____

CREDITOR'S NAME THE KING'S HOSPITAL

CREDITOR'S ADDRESS PALMERSTOWN

DUBLIN 20

IRELAND

TYPE OF PAYMENT

It is imperative one of the below options is ticked.

Half Yearly

8 Monthly

(1st August and 1st January)

(1st August to 1st March inclusive)

DATE OF SIGNING _____

SIGNATURE(S) _____

(ACCOUNT HOLDER)

By signing this mandate form, you authorize (A) The King's Hospital to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instructions from The King's Hospital.

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.