SEPA Direct Debit Mandate

for recurring payments

(Member)

Sächsische Ärzteversorgung
Einrichtung der Sächsischen Landesärztekammer
Körperschaft des öffentlichen Rechts

Sächsische Ärzteversorgung Institution of the Sächsische Landesärztekammer Dr.-Külz-Ring 10 01067 Dresden	

1. Personal details

Surname	First name (preferred name)	
Street, house number		Date of birth
Postal code	City	

2. Bank details

IBAN		
BIC* (*to be stated for international transfers)		
Bank		
Account holder	Surname	First name (preferred name)

3. Authorisation

I authorise Sächsische Ärzteversorgung (SÄV) to collect the payments due from me by direct debit from my account from _____. At the same time, I instruct my bank to honour the direct debits drawn on my account by Sächsische Ärzteversorgung.

Creditor Identifier:	DE31ZZZ00000383046	
Mandate reference:	Membership number	Code* *assigned by SÄV

Note: I may request a refund of the debited amount within eight weeks, starting from the debit date. The terms and conditions agreed with my bank shall apply. Changes to bank details must be notified in writing by submitting a new SEPA Direct Debit Mandate by the 15th of the current month (receipt by Sächsische Ärzteversorgung). Any changes received later can only be taken into account in the following month.

Place, Date	**Handwritten** signature of the account holder