



BANK DEBIT / STOP ORDER INSTRUCTION

SAVINGS PRODUCTS		AMOUNT
Ordinary	<input type="checkbox"/>	P _____
Quick	<input type="checkbox"/>	P _____
Emergency	<input type="checkbox"/>	P _____
Goledwa	<input type="checkbox"/>	P _____
Monana	<input type="checkbox"/>	P _____
Total		P _____

1. MEMBER DETAILS

Initials: Mr Ms Mrs Dr Miss others: _____

Membership No: _____ First Name: _____ Surname: _____

2. BANK DETAILS

Account Number: _____

Bank Name: _____ Branch: _____ Branch Code: _____

NB: transactional cost of P 6.96 will be charged to members in case of insufficient funds.

I _____ hereby request and authorize Motswedi SACCOS to draw against my account with the above-mentioned bank the sum of P _____. This being the amount necessary for the monthly subscription as per our agreement dated _____. Please debit my account on the _____ (Date) of every month.

Sign: _____ Date: _____

MOTSWEDI SAVINGS AND CREDIT COOPERATIVE SOCIETY LIMITED
BOX 81027 GABORONE
TELEPHONE: 390 8227
FAX NO: 319 1534
REGISTRATION NO: 143



TSHWANEANO

3. OFFICIAL USE ONLY

Name: _____ Designation: _____

Signature: _____ Date: _____

CHECKED BY:

Name: _____ Designation: _____

Signature: _____ Date: _____

4. APPROVED BY

1st Name: _____ Signature: _____ Date: _____

Designation: _____