SEPA Direct Debit Mandate

Ark Life
Assurance Company dac

Please complete all the fields below marked * and return this mandate to the Creditor address below

Plan Number (max 18 characters)

Person(s) on whose behalf payment is being made

Direct Debit collection date ____ of the month (1st to 28th only)

Payment frequency Monthly ◯ Quarterly ◯ Half Yearly ◯ Yearly ◯

Name and address of the payer:

* Name of Account Holder(s)

* Address of Account Holder(s)

* City/Postcode

* Country

* Debtor Bank Identifier Code (BIC)

* IBAN

(Account Number)

Type of payment Recurrent ✔

Creditor's name and address

Ark Life Assurance Company dac
PO Box 129
Dublin 1

By signing this mandate form, you authorise (A) Ark Life to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instruction from Ark Life. 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 sign and date

* Signature(s) ✗

✗

* Date of signing d d / m m / y y y y

For Ark Life Information purposes only

UMR

To be completed by Ark Life Assurance Company dac.

Creditor Identifier IE39SDD360073

ILA 10780 (REV 10-16)