

## BILL PAYER DATA FORM

This page must be completed in full and returned to the Finance Department irrespective of whether you are paying by Direct Debit. Please complete in block capitals.

**PUPIL NAME:** \_\_\_\_\_

**BILL PAYER(S) NAME:** \_\_\_\_\_

**BILL PAYER ADDRESS:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**TELEPHONE NUMBERS:** \_\_\_\_\_ (H)

\_\_\_\_\_ (W)

\_\_\_\_\_ (M)

**EMAIL ADDRESS:** \_\_\_\_\_

**BOARDING STATUS:**  Day  5 Day Boarding  7 Day Boarding

**SIBLING(S):** \_\_\_\_\_

Please list all existing or past pupils of the school.

\_\_\_\_\_

**PAYMENT METHOD:**  Cheque / Cash / Bank Transfer  
 Direct Debit (Half Yearly)  Direct Debit (8 Monthly)

If payment method is direct debit (half yearly or 8 monthly) you must complete the Direct Debit Mandate form overleaf.

**SIGNATURE(S):** \_\_\_\_\_

**DATE:** \_\_\_\_\_

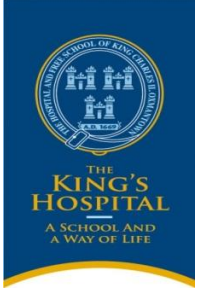
By completing the above information you are agreeing that we may contact you by any of the above means in relation to school fees.

## DIRECT DEBIT MANDATE

This page should only be completed if your selected payment method is Direct Debit.

Please note the direct debit facility is not available to non-Irish bank accounts or overseas students.

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

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

**ACCOUNT HOLDER NAME(S):** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PUPIL NAME(S):** \_\_\_\_\_

**BANK NAME:** \_\_\_\_\_

**IBAN:** \_\_\_\_\_

Irish bank account only

**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

(1<sup>st</sup> August and 1<sup>st</sup> January)

8 Monthly

(1<sup>st</sup> August to 1<sup>st</sup> March inclusive)

**SIGNATURE(S):** \_\_\_\_\_

**DATE:** \_\_\_\_\_

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.