

## SEPA DIRECT DEBIT MANDATE

By signing this mandate form, you authorise (A) Flynn's Dental Care to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instructions from Flynn's Dental Care. 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.

### PLEASE COMPLETE ALL FIELDS MARKED \*

Unique Mandate Reference (UMR) (to be completed by Flynn's Dental Care):

\*Debtor Name(s):

\*Debtor Address:

Republic of Ireland

\*Debtor Bank Identifier Code (BIC):

\*Debtor Account Number (IBAN):

Creditor Identifier:

Creditor's Name: DRS S&H FLYNN TA FLYNNS DENTAL CARE

Creditor Address: 7 CATHAIR DANANN, NORTH CIRCULAR ROAD

TRALEE, CO. KERRY

Country: REPUBLIC OF IRELAND

### \*TYPE OF PAYMENT

Recurrent Payment: ☐ One-Off Payment: ☐

\*Signature(s)

\*Date of Signature:

Please complete this form & return to: FLYNNS DENTAL CARE, 7 CATHAIR DANANN, NORTH CIRCULAR ROAD, TRALEE, CO. KERRY

Note: Your rights regarding the above mandate are explained in a statement that you can obtain from your bank.

NOTE: If paying by monthly Direct Debit, this will be collected in or around the 8th of every month.

The amounts to be debited are variable and may be debited on various dates.

FLYNNS DENTAL CARE require written notification in the event of canceling this instruction.