Contact Persons name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, THE UNDERSINGNED take full responsibility for the payment of my account/s. Should the account not be paid as per agreed Payment of Terms, I agree that I will be responsible for collection cost inclusive, but not to be limited to tracing fees, collection commission, fees on attorney, and client scale as well as interest calculated to two, (2) %.

Please attach a copy of your ID Document, Municipal Account, en CK / PTY LTD documents to sales@dieregesondheid.co.za If Sole Proprietor, please state so in above.

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