Post Office
We deliver, whatever it takes.

REFUND REQUEST FORM
ELECTRONIC FUNDS TRANSFER

Please fax the completed form to **086 244 5005**
Required fields are indicated with a (*****)

Please indicate the reason for your refund request:

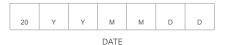1) Incorrect Account Paid ☐
2) Duplicate Payment for the same Account ☐

PERSON REQUESTING THE REFUND

Field	
ID/PASSPORT NUMBER *	
FIRST NAMES *	
SURNAME *	
CONTACT NUMBER *	
EMAIL ADDRESS *	

DETAILS OF ACCOUNT THAT WAS PAID

Field	
ACCOUNT NUMBER *	
POST BOX/PRIVATE BAG NUMBER *	
POST OFFICE/COLLECTION POINT *	
TRANSACTION DATE *	Y Y Y Y M M D D
PAYMENT REFERENCE NUMBER	
AMOUNT PAID *	R AMOUNT IN WORDS

DETAILS OF BANK ACCOUNT USED FOR PAYMENT

Field	
ACCOUNT HOLDERS NAME *	
ACCOUNT NUMBER *	
FINANCIAL INSTITUTION *	
ACCOUNT TYPE	
BRANCH NAME *	
BRANCH CODE *	

ADDITIONAL COMMENTS

I, _____ agree that the information provided above is accurate. I have read and accept the terms and conditions for payments and refunds as stated on the ePostal Online Service (www.epostal.co.za)

_____
SIGNATURE

20	Y	Y	M	M	D	D

DATE

Please Note: (1) A refund will be processed within 15 working days after receipt date of a complete Refund Request Form, (2) Proof of Payment is required before a refund can be processed, (3) Refunds will ONLY be made into the bank account which the original payment was made from.

FOR OFFICE USE ONLY

PROCESSOR		CHECKED BY	
DATE	Y Y Y Y M M D D	DATE	Y Y Y Y M M D D
SIGNATURE		SIGNATURE	
PAYMENT REFERENCE NUMBER			
PAY_REFUND CALL REFERENCE NUMBER			