DR. MATTRESS APPLICATION FORM

1. Name……ID NO……

2. Mobile Number …….. Email address……..

3. Credit Card No.: ☐☐☐☐XXXX☐☐☐☐. (Only first 4 and last 4 digits).

4. KCB account Number (if applicable) ……

5. Fill the table below for products/services you are purchasing *(refer to invoice)*

Name of Product(s)	Qty	Cost
Total Cost		

I authorize KCB Card Centre to debit my credit card account with Kes ……. on monthly basis for…… Months on the card due date, being payment for the above Dr. Mattress products I have chosen.

Repayment period (months)	Tick your selection
3 Months	
4 Months	
5 Months	
6 Months	
7 Months	
8 Months	
9 Months	
10 Months	
11 Months	
12 Months	

I understand that by signing this request, I have agreed to be fully liable in fully paying for the products.

All goods purchased shall be checked before accepting delivery and will remain under manufacturer's warranty for stated period on warranty card.

Dr. Mattress Branch…… (Where products are being purchased)

Signature …….. Date……..

(Customer to sign)

Signature …….. Date……..

(KCB Card Center to sign)

FOR OFFICIAL USE ONLY

PAYMENT	AMOUNT (KES)	APPROVAL CODE	SIGN
1ST Instalment			
Balance			