WITHDRAWAL / CANCELLATION FORM

(Complete and return this form only if you wish to withdraw from the contract.)

To

Dental Health Foundation Ireland
Block A, Unit 5, Leopardstown Office Park, Sandyford, Dublin 18. D18 X3X7

Info@dentalhealth.ie

01 2136112

Consumer Details

Full Name:

Address:

Email Address:

Telephone Number (optional):

Order Details

Order Number:

Date Ordered:

Date Received:

Withdrawal Statement

I/We (*) hereby give notice that I/We (*) withdraw from my/our (*) contract of sale for the following goods:

Refund Information (Optional)

Preferred contact email for refund correspondence:

Signature

(Only if this form is submitted on paper)

Signature of Consumer(s):

Date:

(*) Delete as appropriate.

Website Notice

You may submit this form by:

- Email to: **info@dentalhealth.ie**
- Post to: **Dental Health Foundation Ireland, Block A, Unit 5, Leopardstown Office Park, Sandyford, Dublin 18. D18 X3X7**

Consumers have the right to withdraw from an eligible distance contract within 14 days without giving any reason. The withdrawal period expires 14 days after the day on which the consumer, or a third party indicated by the consumer (other than the carrier), acquires physical possession of the goods. Certain products may be exempt from the right of withdrawal where permitted by law.