HCF

EZIPAY DIRECT DEBIT REQUEST FORM

I/We ____

Authorise The Hospitals Contribution Fund of Australia Limited User ID Number 245164 to arrange for funds to be debited from my/our account at the financial institution below and as prescribed below through the Bulk Electronic Clearing System (BECS).

This authorisation is to remain in force in accordance with the terms described in the HCF Direct Debit Customer Service Agreement.

Details of the account to be debited (all details must be supplied)

Name of financial institution ______________________________

Branch ______________________________

Account holder name ______________________________

BSB number ______________________________

Account number ______________________________

Note: Direct Debit is not available on all accounts. If in doubt please refer to your Financial Institution.

Payment details

The payment is for (member's full name) ______________________________

HCF Membership number ______________________________

Payment frequency

Please circle: Weekly Fortnight Monthly Quarterly Half yearly Yearly

On the ______ day* of the month (please note: debit dates of 28, 29, 30 and 31 are not available)

* Please nominate your first debit day.

Declaration

I declare that the information I have provided is correct and I authorise the use of my account for the direct debit.

Account holder's signature ______________________________ Date ______________

Direct Credit of benefits on Extras claims

Would you like claims benefits to be paid directly into this account (please circle): Yes No

Complete and send to:

HCF
GPO Box 4242
Sydney NSW 2001

Office use only: Batch No.