

## CREDIT CARD AUTHORITY FORM

Member's full name \_\_\_\_\_

HCF membership number \_\_\_\_\_

Type of card (please circle):                  Visa                          Mastercard                          American Express

Debit frequency (please circle):                  Monthly                          Quarterly                          Half yearly                          Yearly

Please debit my nominated credit card account on the \_\_\_\_\_ day of the month (please note: debit dates of 28, 29, 30 and 31 are not available)

Card number               

Expiry date     /

Cardholder name \_\_\_\_\_

I acknowledge that the credit card I am using to pay for this insurance has been issued and used prior to paying for this insurance. HCF reserves the right to vary deductions given any change in product transfer or rates. If processing cannot be done on the nominated date (e.g. weekends) your payment will be processed on the following business day. Written notification is required to cancel this authority and this request should be sent to HCF at least 48 hours prior to the debit date.

Cardholder's signature \_\_\_\_\_ Date \_\_\_\_\_

Complete and send to:  
**HCF**  
**GPO Box 4242**  
**Sydney NSW 2001**