

HCF Payment Authority Form

Complete the HCF Group Payroll Deduction Authority if paying through your employer.
 Complete Credit Card Authority if paying by Credit Card.
 Complete the Ezipay Direct Debit Request if paying through bank, building society or credit union debit.

Complete and return to:
 HCF, GPO Box 4242, Sydney NSW 2001.
 Fax 1800 045 563
 Visit any one of our branches

HCF Membership No.

1 Member's personal details (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Title First name Middle initial

Surname Sex (Please mark 'X')
 M F

Home address:
 Unit No. Street No. Street name

Suburb State Postcode

Phone - home Phone - work Mobile

Postal address (if different from your home address)

Suburb State Postcode

Email @ . .

Date of birth (DD MM YYYY) Date you wish your membership to commence (DD MM YYYY)

2 Payment method (Please mark 'X')

HCF offers you a number of easy ways to pay your premiums. Please fill out one of the options below to pay your premiums automatically.

Payroll deduction (please complete Section 2a) Ezipay Direct Debit (please complete Section 2c)

Credit Card Authority (please complete Section 2b)

a) Group Payroll Deduction Authority

Payroll deductions are available only when your employer has an arrangement with HCF.

Employer's name Payroll or employee ID

I hereby authorise my employer to deduct from my wages or salary. (Please mark 'X')
 Weekly Fortnightly Monthly Quarterly Half yearly Yearly

Employee's personal details

Title First name Middle initial Membership No. (if already a member)

Surname (DD MM YYYY) This date marks the end of the first deduction pay period Total contribution deductions (if known)

Other contribution details

If you are currently paying for other HCF memberships please give their details below:

Full name

Membership No.

Health \$

More Protection \$

Total \$

b) Credit Card Authority

Cardholder name (exactly as it appears on your card)

Type of card (Please mark 'X')

Visa Mastercard American Express

Debit frequency (Please mark 'X')

Monthly* Quarterly* Half yearly* Yearly*

+

Credit card No.

Expiry date (MM YY)

I authorise HCF to debit my account on the day* of the month

(*Please nominate day: **Debit dates of 28, 29, 30 and 31 are not available**)

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

c) Ezipay Direct Debit Request

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 and as prescribed below through the Bulk Electronic Clearing System (BECS).

(Please mark 'X')

Weekly Fortnightly Monthly*

Quarterly* Half yearly* Yearly*

(DD MM YYYY)

Please debit on the day* of the month. First debit to occur on

(*Please nominate day: **Debit dates of 28, 29, 30, 31 are only available for weekly and fortnightly debits**)

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

Name of financial institution

BSB No.

Account No.

Branch

Account holder name (first initial and surname)

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

3 Declaration (Please read and sign)

I acknowledge and agree:

Where payment method is Group Payroll Deduction, I authorise my employer to deduct from my wages or salary.

Where payment method is Credit Card Deductions, I authorise HCF to debit the account nominated.

Where payment method is Ezipay Direct Debit Deduction, I authorise HCF to debit the account nominated.

I declare the information provided to be true & correct.

Member's signature

X

Date (DD MM YYYY)

Account holder's signature
or Cardholder's signature
(if different from member)

X

Date (DD MM YYYY)

The Hospitals Contribution Fund of Australia Limited. ABN 68 000 026 746 AFSL 241 414
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