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B. CREDIT CARD AUTHORITY

I authorise The Hospitals Contribution Fund of Australia Limited to debit my credit card set out below. I agree to be bound by the terms described in the HCF Direct Debit Customer Service Agreement and this authorisation is to remain in force in accordance with these terms. 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 Vearly Monthly not available	e for Ambulance Cover only
Credit card No.	Expiry date (MMYY)	(DD MM YYYY)

6 **DECLARATION**

(Please read and sign. Before you apply, ask staff for a copy of the HCF Ambulance and Cash Back Cover Brochure, or download at hcf.com.au)

I acknowledge and agree that:

- I have the authority to act and give consent on behalf of other persons to be covered under the policy, to provide their information (including sensitive information) and to receive from HCF their information for the purposes of the policy;
- I am the policyholder who is responsible for payment of the contribution rates, the ongoing maintenance of the policy, and the receipt of all policy correspondence;
- I am bound by the Fund Rules of The Hospitals Contribution Fund of Australia Limited (available on the HCF website and from HCF branches); and
- HCF deals with personal information of all members in accordance with the HCF Privacy Policy (available on the HCF website and from HCF branches) and I have informed them of this.

I confirm that I have read and understand:

- this declaration and the information relating to my product choice in the HCF Ambulance and Cash Back Cover Brochure (including any applicable exclusions and waiting periods) and members' privacy (including the HCF Privacy Policy and the Privacy Statement); and
- the Product Disclosure Statement and Financial Services Guide in the HCF Ambulance and Cash Back Cover Brochure for any Cash Assist options I have chosen.

I authorise payment by the method indicated on the form and have the authority to do so.

I agree that my insurance will commence once my application is accepted.

I declare the information provided to be true and complete and I understand that giving false or misleading information is a serious offence.

Signature must be of the Policyholder or Partner listed on Policy

X

Date	(DD	MM	YYY	Y)	

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

HCF House 403 George Street, Sydney, NSW 2000 Postal Address: GPO Box 4242, Sydney NSW 2001

hcf.com.au