APPLICATION FOR REFUND OF CONTRIBUTIONS

Complete and mail to:
HCF
GPO Box 4242
Sydney NSW 2001
or email:
customersupport@hcf.com.au

HCF Membership No.

1 YOUR PERSONAL DETAILS (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Title | First name | Middle initial

Surname | Gender (Please mark 'X') M F | Date of birth (DD MM YYYY)

Home address

Suburb | State | Postcode

Phone - home | Phone - work | Mobile

Postal address (if different from your home address)

Suburb | State | Postcode

Email address

2 REFUND

What is the reason for requesting a refund?

Any refund due will be paid back to either the credit card or bank account that the premiums have been taken from. If this is not possible, a refund cheque will be issued.

Signature of policyholder
X

Date (DD MM YYYY)

How HCF collects, uses, discloses (which may include obligations to overseas recipients in compliance with its privacy obligations) and keeps and secures personal information including how to opt out from direct marketing, how to request access to and correction of your personal information or how to complain about a privacy breach and how this is handled by HCF is explained in the HCF privacy policy. For a copy of this policy, call our member services team on **13 13 34** or go to **hcf.com.au**.

OFFICE USE ONLY

REFUND PERIOD

Date from (DD MM YYYY) | Date to (DD MM YYYY) | Health Policy No. | Refund method (e.g. CC/ER)

Group/Ezipay reversals checked | Claims history checked | Reason code

Calculated refund amount
$.

Refund calculated by | Checked and authorised by | Date (DD MM YYYY)