

## PAYMENT AUTHORITY

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 mail to:  
**HCF**  
**GPO Box 4242**  
**Sydney NSW 2001**  
or email:  
**join.cancel@hcf.com.au**

HCF Membership No.

### 1 MEMBER'S PERSONAL DETAILS (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Date of birth (DD MM YYYY)	Title	First name	Middle initial
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Surname	Gender (Please mark 'X')	Date your membership is to commence (DD MM YYYY)	
<input type="text"/>	M <input type="checkbox"/> F <input type="checkbox"/>	<input type="text"/>	
Home address			
<input type="text"/>			
Suburb	State	Postcode	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Phone - home	Phone - work	Mobile	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Postal address (if different from your home address)			
<input type="text"/>			
Suburb	State	Postcode	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Email address			
<input type="text"/>			

### 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.

Ezipay Direct Debit (please complete Section 2a)       Credit Card Authority (please complete Section 2b)   
Payroll Deduction (please complete Section 2c)

#### A. 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\*

Please debit on the  day\* of the month. First debit to occur on  (DD MM YYYY)  
(\*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.
<input type="text"/>	<input type="text"/>	<input type="text"/>
Branch	Account holder name (first initial and surname)	
<input type="text"/>	<input type="text"/>	

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

### 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 (MMYY)

Please 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. 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 details

Title

First name

Middle initial

Surname

Date marking the end of the first deduction pay period (DD MM YYYY)

#### Other contribution details

If you wish to pay for other HCF memberships please give their details below:

Membership No.

Full name

Health \$

Total contribution deductions (if known)

Cash Assist \$

Membership No.

Full name

**Total \$**

### 3 DECLARATION (PLEASE READ AND SIGN)

I acknowledge and agree that:

- 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 all information provided on this form to be true and complete.

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](http://hcf.com.au).

Member's signature

Date (DD MM YYYY)

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

Date (DD MM YYYY)