

Frequency of Payment

I'd like my premiums to be deducted: Fortnightly (Not available for accounts) Monthly Quarterly 6 monthly

Please complete ONE of the options below.

Option 1 - Bank Account Deduction

I/we authorise Health Care Insurance Limited (Debit user ID 16895) to arrange for funds to be debited from my/our nominated account at the Financial Institution shown below according to the instructions specified.

Name of Financial Institution Branch

Name of account holder

BSB number / Account number

Please use this account for credit of benefit payments. Please use alternative account details for credit of benefit payments (as detailed below)

Name of Financial Institution Branch

Name of account holder

BSB number / Account number

Account Holder 1 Signature Date / /

Account Holder 2 Signature Date / /

Option 2 - Credit Card Deduction

Type of credit card MasterCard VISA American Express

Card number

Name on credit card Expiry date /

I/we acknowledge that this Direct Debit arrangement is governed by the terms of the Direct Debit Request – Service Agreement received from you.

Card Holder's Signature Date / /

Option 3 - Accounts

Accounts Frequency Monthly Quarterly 6 monthly Signature

I wish to receive an account based on the frequency selected above. I undertake to pay all amounts payable by the due date specified on my account.

Telephone and internet banking - BPAY options available. Contact your bank, credit union or building society to make this payment from your cheque, savings or credit card account. For more information go to www.bpay.com.au

Option 4 - Payroll deductions

I authorise the pay officer of to deduct from my pay \$

Payroll Frequency Weekly Fortnightly Monthly Commencing Pay Period Ending / / Payroll ID

This authorisation extends to any changes to my contributions that the Fund may make from time to time.

This authority is to continue until such time as it is withdrawn by me in writing.

Signature Date / /

Direct Debit Request - Service Agreement

The following is your Direct Debit Service Agreement with **Health Care Insurance Ltd**. The agreement is designed to explain what your obligations are when undertaking a Direct Debit arrangement with us. It also details what our obligations are to you as your Direct Debit Provider.

We recommend you keep this agreement in a safe place for future reference. It forms part of the terms and conditions of your Direct Debit Request (DDR) and should be read in conjunction with your DDR form.

Definitions

- 📌 **account** means the account held at your financial institution from which we are authorised to arrange for funds to be debited.
- 📌 **agreement** means this Direct Debit Request Service Agreement between you and us.
- 📌 **banking day** means a day other than a Saturday or a Sunday or a public holiday listed throughout Australia.
- 📌 **debit day** means the day that payment by you to us is due.
- 📌 **debit payment** means a particular transaction where a debit is made.
- 📌 **direct debit request** means the Direct Debit Request between us and you.
- 📌 **us** or **we** means **Health Care Insurance Ltd**, (the Debit User) you have authorised by signing a direct debit request.
- 📌 **you** means the customer who signed the Direct Debit Request.
- 📌 **your financial institution** means the financial institution nominated by you on the DDR at which the account is maintained.

1. Debiting your account

By signing a *Direct Debit Request*, you have authorised us to arrange for funds to be debited from *your account*. You should refer to the *Direct Debit Request* and this agreement for the terms of the arrangement between us and you.

We will only arrange for funds to be debited from your account as authorised in the *Direct Debit Request*.

If the *debit day* falls on a day that is not a *banking day*, we may direct your *financial institution* to debit *your account* on the following *banking day*. If you are unsure about which day *your account* has or will be debited you should ask your *financial institution*.

2. Amendments by us

We may vary any details of this agreement or a *Direct Debit Request* at any time by giving you at least fourteen (14) days' written notice.

3. Amendments by you

You may change, stop or defer a debit payment, or terminate this agreement by providing us with at least seven (7 days) notification by writing to: Health Care Insurance, Attn: Membership Department, PO Box 931, Burnie TAS 7320 or enquiries@hcilt.com.au or by telephoning us on **1800 804 950** during business hours or arranging it through your own financial institution.

4. Your obligations

Is *your* responsibility to ensure that there are sufficient clear funds available in *your account* to allow a *debit payment* to be made in accordance with the *Direct Debit Request*.

If there are insufficient clear funds in *your account* to meet a *debit payment*:

- (a) *you* may be charged a fee and/or interest by your *financial institution*;
- (b) *you* may also incur fees or charges imposed or incurred by us; and

(c) *you* must arrange for the *debit payment* to be made by another method or arrange for sufficient clear funds to be in *your account* by an agreed time so that we can process the *debit payment*.

You should check *your account* statement to verify that the amounts debited from *your account* are correct

If **Health Care Insurance Ltd** is liable to pay goods and services tax ("GST") on a supply made in connection with this *agreement*, then you agree to pay **Health Care Insurance Ltd** on demand an amount equal to the consideration payable for the supply multiplied by the prevailing GST rate.

5. Dispute

If *you* believe that there has been an error in debiting your *account*, *you* should notify us directly on **1800 804 950** and confirm that notice in writing with us as soon as possible so that we can resolve your query more quickly. Alternatively you can take it up with your financial institution direct.

If we conclude as a result of our investigations that *your account* has been incorrectly debited we will respond to *your* query by arranging for *your financial institution* to adjust *your* account (including interest and charges) accordingly. We will also notify you in writing of the amount by which *your account* has been adjusted.

If we conclude as a result of our investigations that *your account* has not been incorrectly debited we will respond to *your* query by providing *you* with reasons and any evidence for this finding in writing.

6. Accounts

You should check:

- (a) with *your financial institution* whether direct debiting is available from *your account* as direct debiting is not available on all accounts offered by financial institutions.
- (b) *your* account details which you have provided to us are correct by checking them against a recent *account* statement; and
- (c) with *your financial institution* before completing the *Direct Debit Request* if you have any queries about how to complete the *Direct Debit Request*.

7. Confidentiality

We will keep any information (including *your account* details) in your *Direct Debit Request* confidential. We will make reasonable efforts to keep any such information that we have about *you* secure and to ensure that any of our employees or agents who have access to information about *you* do not make any unauthorised use, modification, reproduction or disclosure of that information.

We will only disclose information that we have about *you*:

- (a) to the extent specifically required by law; or
- (b) for the purposes of this *agreement* (including disclosing information in connection with any query or claim).

8. Notice

If you wish to notify us in writing about anything relating to this *agreement*, you should write Health Care Insurance, Attn: Membership Department, PO Box 931, Burnie TAS 7320 or enquiries@hcilt.com.au.

We will notify you by sending a notice in the ordinary post to the address you have given us in the *Direct Debit Request*.

Any notice will be deemed to have been received on the third *banking day* after posting.