

Payment Options

1. Direct Debit

Member #

Name

I / We request ACA Health Benefits Fund user ID 031606 to arrange for funds to be debited from my / our nominated account at the financial institution shown below according to the specified schedule. I agree that in the event of changes to premiums, transfer of product or arrears payment, I authorise ACA Health to alter the amount from the appropriate date in accordance with such changes.

Name of Financial Institution:

Account Name:

| | | | | | | |
|----------------------|----------------------|----------------------|---|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | - | <input type="text"/> | <input type="text"/> | <input type="text"/> |
|----------------------|----------------------|----------------------|---|----------------------|----------------------|----------------------|

BSB:

Account Number:

Frequency: Monthly Quarterly

Premiums are deducted in advance on the 20th of the Month, or the next working day after

Signed:

Date:

 / /

2. Credit Card

I / We request ACA Health Benefits Fund to charge my / our nominated credit card according to the specified schedule. I agree that in the event of changes to premiums, transfer of product or arrears payment, I authorise ACA Health to alter the amount from the appropriate date in accordance with such changes.

Visa MasterCard

Cardholder's Name

4 Digit Expiry Date

| | | | | | | | | | | | | | | | | |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|

Card #

Frequency: Monthly Quarterly

Premiums are deducted in advance on the 20th of the Month, or the next working day after

Signed:

Date:

 / /

3. Payroll Authority

I hereby give authority for payroll deductions for my appropriate premiums to be made as follows:

Employer:

Employer Signature:

Date:

Member Name:

Signature:

Date:

Please return to ACA Health Benefits Fund

Locked Bag 2014, Wahroonga, NSW 2076 Fax: (02) 9847 3357 E-mail: acahbf.info@acahealth.com.au