



Claiming Benefits by Direct Credit

Complete this form to permanently retain your bank details on your membership for the payment of your claims direct to your bank account. You can also use this form to let us know if your bank details have changed.

Member #	Name of Policy Holder:
----------	------------------------

Bank Account Details - default account for all benefit payments on the membership

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:

Bank Account Details for an Authorised Insured Person (Optional)

If you would like to nominate a separate bank account for claims relating to an authorised person (must be a spouse or partner) on the membership, please complete the section below.

Name of Authorised Insured Person:

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:

I/We request ACA Health Benefits Fund to arrange for benefits claimed to be credited to my/our nominated account at the financial institution shown below and agree to the following conditions:

1. If the nominated bank account changes the Fund must be notified in writing;
2. Where incorrect payment details have been provided by the claimant (policy holder or an authorised insured person) the claimant is responsible for all costs associated with the recovery of the payment. Where the claimant is unwilling to pay the cost to recover the amounts paid by the fund in satisfaction of the claim, the claimant's benefit entitlement in relation to the claim is considered extinguished by the health fund.

I have read, understood and agree to the conditions of establishing a direct credit authority as outlined above.

Signed: (Policy Holder and/or Authorised Insured Person)

Date:

--

--

Please return to ACA Health Benefits Fund: