Authorised Benefit Recipient Permission Form

ACA HEALTH BENEFITS FUND

Locked Bag 2014
148 Fox Valley Rd
Wahroonga
NSW 2076

Phone 02 9847 3390
or 1300 368 390

Fax 02 9847 3357

Web www.acahealth.com.au

Member Name: _____

Membership Number:_____

I _____, give my permission for_____
to be able to claim eligible health expenses on my membership.

In so doing I understand that this authorised benefit recipient will be receiving benefit payments directly for any eligible claims made on expenses paid by them.

Signed:_____ Date:_____

Contact Details for the Authorised Benefit Recipient

Address:

_____

Ph:_____(Home)_____(Work)_____(Mob)

Please return this form to ACA Health Benefits Fund where it will be kept on file for your convenience until further written instruction to change this arrangement is received.

Thank you.