



Payment Changes

Complete this form by choosing **one** of the below three options to permanently change your bank details for payment towards your membership.

Membership #:

Name of Policy Holder:

Please change my membership & pay the appropriate contributions from

/ /

1. Bank Account - Direct Debit

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

BSB -

Account Number

Frequency: Monthly Quarterly Yearly

Please Note: Premiums are deducted in advance on the 20th of the month, or the next working day

Signed:

Date:

2. Credit Card - Direct Debit

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.

Name of Financial Institution

Account Name

Visa

MasterCard

Card Number

Exp Date Frequency: Monthly Quarterly Yearly

Please make a catch up payment using this card

Please Note: Premiums are deducted in advance on the 20th of the month, or the next working day

Signed:

Date:

Please return to ACA Health Benefits Fund

Locked Bag 2014 Wahroonga NSW 2076 | Email: info@acahealth.com.au

3. Individual Payer

I/We would like to make payments towards the membership either by credit card over the phone, via Online Member Services or by Bpay. I/We understand that this means it will be my/our responsibility to make payments towards the membership and keep the membership up-to-date.

Please send me my Bpay details via email to the address below.

Email:

Signed:

Date:

4. Payroll Deduction

Currently only available to employees of:

Sydney Adventist Hospital, Sanitarium Health Food Company, Signs Publishing Company, South Australian Conference, and Elizabeth Lodge Adventist Retirement Village

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

Payroll Officer:

Signature:

Date:

Policy Holder:

Signature:

Date: