Payment Changes

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

Policy Holder's Details

Member #:	Name of Policy Holder:
Please change my membership & pay the appropriate contributions from: / /	

Option 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.

Bank:	Account Name:
BSB:	Account Number:
Frequency: ☐ Monthly ☐ Quartely ☐ Yearly	
Please Note: Premiums are deducted in advance on the 20th of the month, or the next working day	
Signature: ✕	**Date: / /**

Option 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 on Card:	
☐ VISA ☐ Mastercard	Card Number:
Expiry 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	
Signature: ✕	**Date: / /**

Option 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:	
Signature: ✕	**Date: / /**

Option 4: Payroll Deduction

Currently only available to employees of:

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: / /**

Please return to: ACA Health Benefits Fund to info@acahealth.com.au OR Locked Bag 2014 Wahroonga NSW 2076