



Section Eight Payment Method Required - please tick one of the two options

1. Direct Debit - From your Financial Institution or Credit Card [complete direct debit request]
 Payment Frequency (please indicate one of the following): Fortnightly Monthly Quarterly Half Yearly Yearly
 Please nominate the date you would like the deduction to commence: ____/____/____
2. Statement - Please indicate frequency: Quarterly Half Yearly Yearly

Direct Debit Request

Name and address of the financial institution where the account is held:
 Name of Institution: _____
 Branch: _____
 Address: _____

Applicant's details:
 Surname: _____
 Given names: _____
 Postal Address: _____
 _____ Postcode: _____

I/We authorise and request HealthGuard Health Benefits Fund Limited trading as Central West Health Cover User ID: 241207 (Debit User), until further notice in writing, to arrange for my/our account described in the schedule above, to be debited with any amounts which the Debit User may properly debit or charge me/us through the Direct Debit System.

- I/We:
1. authorise and request that this Direct Debit Request remain in force until cancelled, deferred or otherwise altered in accordance with the Service Agreement;
 2. have read and understand the Service Agreement attached and agree to its terms; and
 3. agree that an electronic reproduction of this document, or any other information in this document, will have the same legal effect as the original of this document; and
 4. have read the Service Agreement below and agree to its terms; and
 5. agree that an electronic reproduction of this document, or any other information in this document, will have the same legal effect as the original of this document.

Payment Method

If paying by CHEQUE OR SAVINGS account:
 Account in the name of: _____
 BSB / Financial Institution Number: _____
 Account Number: _____
 Please note that the number on your access card is not necessarily your account number. If in doubt, check with your Financial Institution.

Two signatures are required if it is a joint account.
 Signature: _____ Date: ____/____/____
 Signature: _____ Date: ____/____/____

OR

If paying by CREDIT CARD, please complete the following:
 MasterCard Visa
 Card Number: _____
 Expiry date on card: ____/____
 Signature: _____ Date: ____/____/____
 Member Number: _____

Please detach this section and keep for your records

direct debit request service agreement



1. Central West Health Cover User ID Number 241207 ("Debit User") will initiate direct debit payments in the manner referred to in the Schedule.
2. Debit payments will be made when due. Central West Health Cover will not issue individual confirmation of payments made.
3. Central West Health Cover will give the customer at least 14 days written notice if Central West Health Cover proposes to vary details of this arrangement, including the amount and frequency of payments.
4. If the customer wishes to defer any payment or alter any of the details as referred to in the Schedule, the customer must contact Central West Health Cover on 133 206 or write to Central West Health Cover at PO Box 10860, Kalgoorlie WA 6433.
5. Any queries concerning disputed debit payments must be directed to Central West Health Cover in the first instance. Customers may obtain details of the claims process by contacting Central West Health Cover on 133 206 or writing to Central West Health Cover at PO Box 10860, Kalgoorlie WA 6433.
6. Direct debiting is not available on the full range of accounts at all financial institutions. If in doubt, the customer should check with their financial institution at which the account is held.
7. The customer should ensure that the account details given in the Schedule are correct by checking them against a recent statement from the financial institution at which the account is held.
8. By signing the Direct Debit Request, the customer warrants and represents that he/she/they is/are duly authorised to request the debiting of payments from the account in the Schedule.
9. It is the customer's responsibility to have sufficient cleared funds available in the account to be debited to enable debit payments to be made in accordance with their Direct Debit Request.
10. If the debit payment falls due on any day which is not a business day, the payment will be made on the next business day.
11. If a debit payment is returned unpaid, the customer may be charged a fee for each unpaid item.
12. Customers wishing to cancel the Direct Debit Request or to stop individual debit payments must contact Central West Health Cover on 133 206 or write to Central West Health Cover at PO Box 10860, Kalgoorlie WA 6433. before the day their payment is due to be debited.
13. Except to the extent that disclosure is necessary in order to process debit payments, investigate and resolve disputed transactions or is otherwise required by law, Central West Health Cover will keep details of the customer's account and debit payments confidential.

membership application



central west
health cover

