Direct Credit/Debit Cancellation

HealthPartners

You can use this form to cancel your direct debit (payment of premiums) and/or direct credit (payment of benefits).

Member details

Member Number

Name *(first name)* *(surname)*

Address

Postcode

Please cancel my

☐ Direct Debit authority *(payment for premiums)* ☐ Direct Credit authority *(payment for claim benefits)*

I wish to cancel my authority effective from / /

Bank account details

Name of financial institution

Name of branch

Account in the name/s of

BSB number - Account number

Signature (for joint accounts both to sign)

OR Credit Card Details

Type of Credit Card ☐ Visa Card ☐ MasterCard ☐ American Express

Name on Credit Card

Number of Card ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Signature Expiry date /

Declaration

- I declare that I am the policyholder or authorised to sign this application.

Signature Date / /