

Responsible Party to complete all of Section 1 and any other details that require amending in Section 2 and Section 3

### 1. YOUR CURRENT MYHEALTHCARE ACCOUNT DETAILS (RESPONSIBLE PARTY)

Please complete the following so we can locate your MyHealthCare Payment Plan Account

*First Name	*Last Name	*DOB (DD/MM/YY)
<input type="text"/>	<input type="text"/>	<input type="text"/>
*Residential Address	*Mobile Phone Number	
<input type="text"/>	<input type="text"/>	
*Suburb	*Postcode	*MyHealthCare Account Number
<input type="text"/>	<input type="text"/>	<input type="text"/>

### 2. CHANGE OF RESPONSIBLE PARTY'S CONTACT DETAILS

Please complete all fields that require amending

New Residential Address		New Mobile Phone Number
<input type="text"/>		<input type="text"/>
Suburb		New Home Phone Number
<input type="text"/>		<input type="text"/>
State	Postcode	New Work Phone Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
New Email Address		
<input type="text"/>		

### 3. CHANGE OF RESPONSIBLE PARTY'S DEBIT ACCOUNT DETAILS

I/We, authorise and request Payment Advantage Pty Ltd T/A MyHealthCare Payment Solutions ABN 99 107 018 182, until further notice in writing, to arrange for my/our account as described in Schedule 1 or 2 specified below, provided that if no amount is specified, the account may be debited with any amounts which I/we must pay to you under the arrangements. Schedule 1 of this Direct Debit Request allows for Payment Advantage Pty Ltd T/A MyHealthCare Payment Solutions ABN 99 107 018 182 to debit the nominated amount as the Debit User specified in the Bulk Electronic Clearing System (CS2) under Debit User ID No. 317892.

<input type="checkbox"/> <b>Bank Account – Schedule 1</b> \$0.88 fee for bank transactions Account Holder Name (Please complete using CAPITAL LETTERS) <input type="text"/> BSB Number      Account Number <input type="text"/> <input type="text"/> <input type="text"/> Bank or Financial Institution <input type="text"/> Signature on Nominated Account      Date of Signing (DD/MM/YY) <input type="text"/> <input type="text"/>		<input type="checkbox"/> <b>Credit or Debit Card – Schedule 2</b> 1.75% fee MasterCard & Visa transactions. 1.75% fee Amex transactions Name of Cardholder (Please complete using CAPITAL LETTERS) <input type="text"/> Card Number (Visa, MasterCard or Amex) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Expiry Date (MM/YY) <input type="text"/> Signature on Nominated Account      Date of Signing (DD/MM/YY) <input type="text"/> <input type="text"/>	
--	--	---	--

**ACKNOWLEDGEMENT:** I/We have read the Direct Debit Request Service Agreement and the MyHealthCare DDR Payment Plan Terms & Conditions and agree to their terms and conditions. I/We authorise and request that this Direct Debit Request remain in force until cancelled, deferred, or otherwise altered in accordance with the Direct Debit Request Service Agreement. I/We confirm the bank account or credit card details as set out above are correct and this Direct Debit Request is signed by all the authorised signatories required by the financial institution where my/our account is held.

### 4. COMPLIANCE ACKNOWLEDGEMENT

I, as the signing Responsible Party for Payments, agree to the above changes being applied to my MyHealthCare account and agree to the MyHealthCare Direct Debit Request Service Agreement & Payment Plan Agreement

Name of Responsible Party for Payments	Signature	Date of Signing (DD/MM/YY)
<input type="text"/>	<input type="text"/>	<input type="text"/>

## DIRECT DEBIT REQUEST SERVICE AGREEMENT

1. Payment Advantage Pty Ltd, t/a MyHealthCare Payment Solutions and/or MyHealthCare ABN 99 107 018 182 as Debit User (ID No. 317892) will initiate direct debit payments in the manner referred to within the MyHealthCare Direct Debit Request as per Section 3 The Payment Plan and Section 4 Direct Debit Request Schedule 1 or 2.
2. Debit payments will be made when due. MyHealthCare will not issue individual confirmation of payments made. Statements are available on request.
3. MyHealthCare will give you at least 14 days' written notice if MyHealthCare proposes to vary details of this arrangement, including the amount and frequency of payments.
4. If you wish to defer any payment or alter any of the details referred to in the Schedule or Payment Plan, then you must either contact MyHealthCare on 1300 810 321 or write to MyHealthCare at the following address: MyHealthCare PO Box 3156 Southport QLD 4215.
5. Any queries concerning debit payments or disputed debit payments must be directed to MyHealthCare as Debit User in the first instance.
6. Direct debiting is not available on the full range of accounts at all financial institutions. If in doubt, you should check with the financial institution before completing the Direct Debit Request.
7. You 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 this Direct Debit Request, you warrant and represent that you are duly authorised to request the debiting of payments from the account described in the Schedule.
9. The signature used for the Direct Debit Request must be identical to the signature used in connection with your nominated bank account and/or the primary cardholder of the credit card account.
10. It is your responsibility to have sufficient cleared funds available in the account to be debited to enable debit payments to be made in accordance with the Direct Debit Request.
11. If a debit payment falls due on any day which is not a banking business day, the debit payment will be made on the next banking business day. Monthly Direct Debits cannot be scheduled on the 29<sup>th</sup>, 30<sup>th</sup> or 31<sup>st</sup>.
12. If a debit payment is returned unpaid, MyHealthCare may charge you a fee for each unpaid item.
13. If you wish to cancel a Direct Debit Request or stop individual debit payments you must give at least 7 days written notice to MyHealthCare. This may be arranged by calling MyHealthCare on 1300 810 321.
14. Except where the account or banking service terms and conditions permit disclosure, and except to the extent that disclosure is necessary in order to process debit payments, investigate and resolve disputed transactions or is otherwise required or permitted by law, MyHealthCare will keep details of your account and debit payments confidential.

## MYHEALTHCARE PAYMENT PLAN AGREEMENT

1. **By entering into a MyHealthCare DDR Payment Plan you acknowledge and agree that your scheduled direct debit payments and entire payment plan are affordable to you and remains your financial responsibility until the entire payment plan is paid in full.**
2. If a scheduled direct debit fails for any reason the failed scheduled direct debit payment will automatically be rescheduled and transacted within five banking business days, unless otherwise arranged with you by MyHealthCare or its agents.
3. If your financial institution rejects any of our attempts to debit your account, in accordance with your DDR Sections 3 & 4, an irrevocable reprocessing fee of up to \$38.50 will be added to your payment plan and automatically debited from your account.
4. If your MyHealthCare Payment Plan account is in arrears greater than 90 days it shall be deemed in default and the total payment plan amount outstanding may become immediately payable. Legal and debt collection costs incurred by MyHealthCare or its agents in recovering outstanding debt or arrears or scheduled payments from you will be your responsibility and added to the amounts owed by you to MyHealthCare or its agents.
5. Under Part 3A of the Privacy Act a Responsible Party holding a MyHealthCare Payment Plan which is in default will be subject to a default listing with a credit reporting body such as Veda.
6. Under Part 3A of the Privacy Act we may contact a credit reporting body such as Veda to obtain a credit report about you.
7. Your information within your MyHealthCare Payment Plan is required to provide the MyHealthCare service. Your information may be disclosed to third parties relevant to your MyHealthCare Payment Plan and MyHealthCare's internal or external debt collection agencies where necessary.
8. In the event of a dispute relating to your treatment you and your chosen healthcare provider/s are required to provide MyHealthCare full details of your treatment relative to your MyHealthCare Payment Plan and you give consent to your chosen healthcare provider/s to disclose your information directly to MyHealthCare for the purpose of dispute resolution.
9. MyHealthCare will provide at least 14 days' notice of any changes to the terms and conditions of this MyHealthCare Payment Plan Agreement.
10. Any amendments or deferments of any of the debit arrangements as set out in Section 3 of the Direct Debit Request may result in additional fees and charges which you will be advised of at the time.
11. Evidence of your Age, Bankruptcy or Debt Agreement Status, Citizenship and Employment Status may be required from you at any time prior to or during your MyHealthCare Payment Plan. Failure to provide requested detail may result in the cancellation of your MyHealthCare Payment Plan.
12. MyHealthCare reserves the right to reject, suspend or cancel any Payment Plan at any time for breach of this agreement.

## 13. COMPLIANCE ACKNOWLEDGEMENT (Clause 13 of MyHealthCare Payment Plan Agreement Terms & Conditions)

By signing the Direct Debit Request as the Responsible Party for the Payment Plan you acknowledge & confirm that:

- a) **You are providing accurate and valid details within your MyHealthCare Direct Debit Request Payment Plan.**
- b) **You are an Australian Citizen residing permanently in Australia.**
- c) **You are Employed and have Adequate Income to honour the scheduled payments as per your signed Payment Plan.**
- d) **You are 18 years of age or older.**
- e) **You are not subject to bankruptcy or any debt agreements.**