# DIRECT DEBIT SERVICE AGREEMENT

## COUNTRY CARE DENTAL IDP. IN HOUSE DENTAL PLAN

Mail to: Country Care Dental Hamilton
36B Thompson St, Hamilton VIC, 3300
Email to: emily@countrycaredental.com.au
Phone: 07 1234 5678

Member Rates: 1: $29 P/M 2: $49 P/M Each Child: $15 P/M TOTAL P/M: $

**MEMBER 1**

Title Given Names Surname Birth Date

Address City/ Town State Post Code

Home Phone Mobile Phone Email

**MEMBER 2 SPOUSE | PARTNER**

Title Given Names Surname Birth Date

Address City/ Town State Post Code

Home Phone Mobile Phone Email

**MEMBER 3 CHILD**

Title Given Names Surname Birth Date

**MEMBER 4 CHILD**

Title Given Names Surname Birth Date

**MEMBER 5 CHILD**

Title Given Names Surname Birth Date

Signature | Member 1

X

Date

Signature | Spouse | Partner

X

Date

The Member, until further notice in writing, to debit my/our account described in the schedule above. Using BECS.
Membership renews annually on the day & month of initial enrollment.
The Member may cancel this agreement in writing with one months notice prior to the automatic annual renewal.
Patients agree that Country Care Dental fees stated must be paid at the time services are rendered.
Any service not paid for at the time of service will be billed at usual & customary fees.
Cover fees are valid only when paid at the time of enrollment.
All family members must reside in the same household.
This is not an insurance product.

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# DIRECT DEBIT REQUEST

## COUNTRY CARE DENTAL IDP IN HOUSE DENTAL PLAN

Mail to: Country Care Dental Hamilton
36B Thompson St, Hamilton VIC, 3300
Email to: emily@countrycaredental.com.au
Phone: 03 5537 9259

AUTHORITY TO ACCEPT
DIRECT DEBITS
Authorisation Code

## 1 Dental Plan

Starting on Date D D M M Y Y

Debit amount $ .

Frequency Month Year

## 2 Primary Member Details

Given Names

Surname

Address

City/ Town

State

Post Code

## 3 Direct Debit Account Details

Bank Branch Account No Suffix BSB Number

Bank Name

Branch

Town | City

## 4 Or Credit Card Details

Card Number

Expiry Date M M Y Y

VISA MasterCard AMEX

## 5 Declaration

I / we acknowledge that this Direct Debit Request is governed by the terms of the Direct Debit Request Service Agreement.
I / we have read and agree to the terms and conditions.
I / we request and authorise Country Care Dental to debit funds from my /our account until further notice in writing and at the Financial Institution identified above through the Bulk Electronic Clearing System (BECS).

Name of account holder 1 | Primary Credit card holder

Signature of account holder 1 | Primary Credit card holder

X

Date

Name of account holder 2

Signature of account holder 2

X

Date

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