

# Payment authority.



**If your policy starts with a number (not letters) this is your form.**

This form is for Members on Health Positive, Hospital Select Plus Modules, UniCare Advantage, ParentStay and other Health Plans or group insurance schemes issued by UniMed.



A form is not required if you're adding family to an existing policy with a current payment method. Complete and return this form to [members@unimed.co.nz](mailto:members@unimed.co.nz).

**Policy/ Membership Number**

**Phone number**

**Primary Member full name**

First name(s)

Last name

**Payment method** (please select one option only)

Direct debit

Credit card

## A. Direct Debit Authority

Authority to accept Direct Debits  
(Not to operate as an assignment or agreement)

Authorisation code  
0201319

Approved  
0131 01/26

**Name on account** (e.g. John Smith)

**Bank name** (e.g. ANZ, BNZ, Westpac)

**Recurring payment frequency**

**Preferred date of first payment** (dd/mm/yy)

Fortnightly

Monthly

Annually

**Bank account number from which payments are to be debited**

□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □

I/we authorise Union Medical Benefits Society Limited ('the initiator') to send payment instructions to my bank to direct debit my account in accordance with this authority.

**From the acceptor to my bank:**

I authorise you to debit my account with the amounts of direct debit instructions received from the initiator with the authorisation code specified on this authority and in accordance with this authority until further notice from me.

I agree that this authority is subject to:

- my bank's terms and conditions that relate to my account, and
- the terms and conditions listed overleaf.

**Signature/s**

**Signed date** (dd/mm/yy)

## B. Credit Card Authority

Name as it appears on card

Expiry date on card

Credit card payment frequency

Fortnightly      Monthly      Annually

Preferred date of first payment (dd/mm/yy)

**Card type** (Note we only accept Visa or Mastercard. We do not accept other cards such as American Express or Diners Club)

Visa                      Mastercard

**For security reasons, please do not provide your credit card number. Once we receive this form, we will phone you to obtain this information.**

I authorise you until further notice, to debit my card number as detailed above (the "nominated card") with all amounts which Union Medical Benefits Society Limited ("the initiator") may initiate. I acknowledge and accept that the initiator accepts this authority only upon the conditions listed below.

Cardholder's signature

Signed date (dd/mm/yy)

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### Specific conditions relating to notices and disputes – Direct Debit

1. I agree that the initiator must give me at least 10 days' notice prior to each direct debit, provided that where the direct debit is in a series, the initiator is only required to provide 10 days' notice prior to the first direct debit in the series.
2. Changes to the amounts or dates of a series of direct debits require 30 days' prior notice to me.
3. I can also agree with the initiator to receive a same day notice for direct debits specifically requested by me.
4. All notices must be in writing, but can be delivered electronically, if I have agreed that with the initiator.
5. I can also ask you to reverse a direct debit up to 120 days after the direct debit if:
  - I didn't receive proper notice of the amount and date of the direct debit, or
  - I received notice but the amount or date of the direct debit is different from the amount or date on the notice.
6. If you dishonour a direct debit but the initiator retries it within 5 business days of the original direct debit, I understand that the initiator doesn't need to notify me again about that direct debit.

### Conditions of this authority to accept recurring Credit Card payments

1. The initiator agrees:
  - a. To give advance written notice (including by electronic means) to the Customer in the form of a schedule of payment dates and the net amounts to be debited to the Nominated Card.
  - b. In the event of any subsequent change to the frequency or amount of the debits to the Nominated Card, the Initiator has agreed to give advance written notice of at least 10 days to the Customer before the changes comes into effect.
2. The Customer may:
  - a. At any time, terminate this authority by giving written notice of termination to the initiator.
3. The Customer acknowledges that:
  - a. This Authority will remain in full force and effect in respect of all amounts to be debited to my Nominated Card in good faith notwithstanding my death, bankruptcy or other revocation of this authority.