MEMBERSHIP PAYMENT

VICTORIAN HEALTH PROFESSIONALS ASSOCIATION

MY DETAILS	
First Name:	Family Name:
Profession:	Date of Birth:
Home Address:	City:
Postcode:	Home Phone:
Home Email:	Mobile:

EMPLOYMENT	
Primary Employer:	
Primary Worksite Address:	
City:	Postcode:
Work Phone:	Work E-mail:
Other Employer/s:	
Total hours per week employed as a Health Professional:	
Please send VHPA emails to: Home Email Work Email (please circle)	

PAYMENT - PLEASE SELECT ONE METHOD BELOW	
◯ **Direct Debit Request#**	Fortnightly Monthly Quarterly (please circle)
Account Name:	BSB & Account Number:
Financial Institution:	Branch Address:
◯ **Credit Card Payment**	Fortnightly Monthly Quarterly (please circle)
Mastercard Visa (please circle)	Cardholder Name:
Card Number:	Expiry:
◯ **Statement Payment** (available on request – phone 1300 322 917)	

SIGNATURE	
My Signature:	Date:

NB: IT IS IMPORTANT YOUR DETAILS ARE ACCURATE & ALL PAYMENTS ARE UP-TO-DATE TO ENSURE YOUR PROFESSIONAL INDEMNITY INSURANCE REMAINS VALID†

† Terms and conditions apply, call 1300 322 917 for policy details.

I hereby request and authorise VHPA (ABN 38 106 461 384) to arrange, through its own financial institution, a debit to my nominated account any amount VHPA has deemed payable by me. This debit will be made through the Bulk Electronic Clearing System (BECS) from my above-nominated account and will be subject to the terms and conditions of the Direct Debit Service Agreement available at www.vhpa.asn.au . By signing herein I indicate I have understood and agreed to the terms and conditions governing the debit arrangements between VHPA and myself as set out in this Request and in the Direct Debit Service Agreement.