EZYPAY

Direct Debit Request Form - new customers only

Please use BLACK (Preferable) / BLUE BALL POINT PEN. * Compulsory field

Principal Name:

Section A - CUSTOMER INFORMATION

Your Reference ID for this Customer:

Company Name:

* First Name:

* Surname:

* Date of Birth: . . Password:

* Address Line 1:

Address Line 2:

* Suburb: * State: * P/C:

* Phone (M): Phone:

* Email:

Section B - PAYMENT INSTRUCTION IMPORTANT

Fees and charges may apply.
Please allow 5 working days for processing after the form is received by Ezypay

1) First debit or once off debit $. To be debited on: . .

2)

Regular amount $. To be debited every: Month(s) or Week(s) Starting on: . .

☐ Monthly $95 ☐ 3 Month $90 ☐ 6 Month $85 ☐ 12 Month $80 ☐ Off Peak $70 ☐ Student/MOD $70

I/We agree to commit to a minimum term of Direct Debit Membership for a period of ____ months.

Section C - PAYMENT METHOD (please select Bank Account

Name of Institution e.g.("Commonwealth Bank"):

Suburb where branch is located:

Name of Account Holder(s):

BSB Number: - Account Number:

I / we authorise Ezypay Limited APCA User ID Number 064323 to debit my / our accounts at the Financial Institution identified above through the Bulk Electronic Clearing System (BECS)

PROOF OF IDENTIFICATION (STAFF USE ONLY) STAFF INITIALS

☐ DRIVERS LICENCE

Name on Drivers Licence: _____

Drivers Licence No: _____ Expiry Date: ____/____

☐ MEDICARE CARD

Name on Medicare Card: _____

Medicare No: _____ Expiry Date: ____/____

Section D - AUTHORISATION

This authorisation is to remain in force in accordance with the Terms and Conditions on this page and on the reverse side which I/we have read and understood.

DO NOT MARK THIS BOX
EZYPAY REFERENCE NO

1. 2. . .

Signature of cardholder(s) or acount holder(s)

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