WA DEAF SOCIETY Inc.

DIRECT DEBIT REQUEST

CUSTOMERS DETAILS IN FULL

I/We

Title | **Surname** | **Given Name(s)**

Company Name (if applicable) | **ABN / ACN**

Address

Postcode

Authorise and request **WA Deaf Society Inc** (User ID no ***317767***), until further notice in writing, to arrange for my/our account(as described in the Schedule below) to be debited as specified below, provided that if no amount is specified, the account may be debited with any amounts which the Debit User may properly debit or charge me/us through the Direct Debit System:

THE SCHEDULE

Account in the name(s) of

Note: Direct Debiting is not available on the full range of accounts. If in doubt, please refer to your financial institution

Financial Institution Name | **Financial Institution Address**

BSB (full six digits) | **Account Number**

OR **Credit Card** **Expiry Date**

Direct Debit to commence on: (optional)

/ /

Frequency

☐ Weekly ☐ Fortnightly ☐ Monthly

☐ Quarterly ☐ Annually

Amount: (optional)

$

Reason for Payment: (optional)

ACKNOWLEDGEMENT

I/We have read the Service Agreement attached and agree to its terms. I/We authorise and request that this Direct Debit Request remain in force until cancelled, deferred or otherwise altered in accordance with the Service Agreement. I/We confirm account details are correct and that this request is signed by required number of authorised signatories.

Customers Signature | **Date**

/ /

Customers Signature | **Date**

/ /

As a member of the SignOn program you will receipt at the end of the financial year