

Direct Debit Authority

Authority to accept Direct Debits (Not to operate as an assignment or agreement)
Please complete and return to CCS Disability Action
PO Box 6249, Marion Square, Wellington 6141.



TE HUNGA HAUĀ MAURI MŌ NGĀ TĀNGATA KATOA

| | | | |
|--------------------|--|-----------------------|---|
| Title: | <input type="text" value="Mr"/> <input type="text" value="Mrs"/> <input type="text" value="Miss"/> <input type="text" value="Ms"/> | Other: | <input type="text"/> |
| First name: | <input type="text"/> | Family name: | <input type="text"/> |
| Address: | <input type="text"/> | | |
| Suburb: | <input type="text"/> | City/Town: | <input type="text"/> |
| Home: | <input type="text"/> | Work: | <input type="text"/> |
| | | Mobile: | <input type="text"/> |
| Email: | <input type="text"/> | Date of birth: | <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> |

I wish to make a monthly donation of \$ on the (please tick preferred date below)
 1st 10th 20th of the month. First debit date and at monthly intervals thereafter.

- (a) I understand that this is an ongoing donation to CCS Disability Action – **this is not a one-off donation.**
(b) Donations over \$5 are tax deductible.

By Direct Debit

My/Our Banking Details (Bank Account from which payments are to be made).

Authorisation Code
0228788

Name of Bank: **Branch:**

Please provide the branch number, account number and suffix to be debited in the spaces provided below.
Please enclose a deposit slip to ensure your account details are loaded correctly.

Bank Account Number:
BANK BRANCH ACCOUNT NUMBER SUFFIX

Name of Account Holder/s:

Information to appear on my/our Bank Statement

Complete the following boxes to show what references to your donation you would like to appear on your bank statement.

PAYER PARTICULARS PAYER CODE PAYER REFERENCE

I authorize you to debit my account with the amounts of direct debit instructions received from CCS Disability Action Incorporated (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 below.

Authorised Signature/s: Date:

OR by Credit Card

Credit Card Request: I am over 18 years of age

Card Number: VISA MASTERCARD AMEX DINERS

Name on card: Expiry Date:

Cardholders Signature: Date:

For Bank use only

Approved
2878
02 | 2018
Original Retain Branch

| | | |
|----------------|--------------|-------------|
| Date Received: | Recorded By: | Checked By: |
|----------------|--------------|-------------|

BANK STAMP

For Office use only

DD Authority sent to Bank:
Initial:
Date:

SPECIFIC CONDITIONS RELATING TO NOTICES AND DISPUTES

- 1) I agree that the Initiator must give me at least 10 days' prior notice of each direct debit, including the first direct debit in a 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 CARD PAYMENTS

1. The Initiator agrees:

- (a) To give advance written notice (including by electronic means and SMS where the Customer has provided prior written consent to communicate electronically) to the Customer of the payment date and amount of any debit to the Nominated Card.

2. The Customer may:

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 until actual notice of such an event is received by the Initiator.

