



Name _____

Employer _____

Branch/department _____

Employment address _____

Employee number (if applicable) _____

I/We authorise you to deduct the following in relation to the Southern Cross Health Society employer's work scheme:

- a. The contribution appropriate for myself and/or my dependants including any future alterations;
- b. and if applicable, on termination of my employment, sufficient contributions to continue my membership through to the end of the billing period or month;
- c. and if applicable, I acknowledge that this authority in respect of my contributions may only be cancelled at the end of the billing period or month.

Employee signature(s) _____

Date signed ____/____/____

FOR OFFICE USE ONLY

	Self	Spouse	Dependants	Adult dependants
Members covered				
Plan required				
	Cost of plan	\$:	
	Less subsidy (if applicable)	\$:	
	Employee Contribution	\$:	

Weekly Fortnightly Monthly

Entry date ____/____/____

Area stamp code

Group code

Membership number for existing member