REFUND REQUEST FORM 2021

Reg A0103505D ABN 25 6384 23194 PBS ACCREDITATION - C0004Y

Colostomy Association of Victoria Inc.

PHONE 9650 1666 **WWW** colovic.org.au **EMAIL** info@colovic.org.au

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P.O. BOX 65 FLINDERS LANE POST OFFICE, MELBOURNE, VIC, 8009

OFFICE HOURS - 9am to 2pm, Monday to Friday. Closed on all public holidays

REFUND REQUEST FORM – PREPAID PARCEL DELIVERY / POST FUNDS

COMPLETE THIS FORM AND RETURN IT TO THE CAV

The CAV FINANCE team will assess this REFUND CLAIM and notify the outcome

NOTE 1 If funds in a CAV client's account were deposited by a THIRD-PARTY ORGANISATION, then CAV will only arrange a refund to the account of that organization.

NOTE 2 If this REFUND REQUEST is validated by CAV, the following fees and charges may be applied -

GST
A GST ACCOUNT ADJUSTMENT FEE - up to 50% of the GST amount
A $5 ADMINISTRATION FEE
A $5 FINANCE FEE
A $5 BANK TRANSFER / DEPOSIT FEE

CAV CLIENT NAME ______

CAV CLIENT D.O.B. ______

PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT THE PERSON OR BUSINESS (AS APPLICABLE) REQUESTING REFUND

NAME OF PERSON ______

NAME OF BUSINESS ______

ABN OF BUSINESS ______

POSTAL ADDRESS ______

______

PHONE CONTACT ______

EMAIL ADDRESS ______

Tick any of the following that apply to this request

☐ I am the CAV CLIENT
☐ I hold ENDURING POWER OF ATTORNEY on behalf of the CAV CLIENT
☐ I am a relative of CAV CLIENT but do not hold POWER OF ATTORNEY
☐ I represent a THIRD PARTY responsible for CAV CLIENT finances.
☐ Other – please specify:

REASON FOR REFUND REQUEST

☐ CAV CLIENT is deceased
☐ CAV CLIENT is transferring to another association
☐ CAV CLIENT has undergone STOMA REVERSAL SURGERY

SIGNATURE OF PERSON COMPLETING THIS FORM ______ DATED ______

PLEASE PROVIDE DETAILS OF THE BANK ACCOUNT INTO WHICH ANY REFUND MAY BE DEPOSITED

BSB ______

ACCOUNT NUMBER ______

NAME ON ACCOUNT ______