REFUND REQUEST FORM

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

SUITE 221, 98 ELIZABETH STREET, MELBOURNE

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.

REFUND REQUESTS – IF VALIDATED – CAN TAKE UP TO 8 WEEKS TO PROCESS.

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

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

GST – rounded up to the nearest dollar
A $5 ADMINISTRATION FEE
A $5 FINANCE / 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 COMPLETING THIS FORM

NAME OF BUSINESS / ORGANISATION (IF APPLICABLE)

A.B.N. (IF APPLICABLE)

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'm an associate of the CAV CLIENT but don't 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