Dental Members
AUSTRALIA
YOUR PAYMENT PLAN PARTNER

DMA Membership Cancellation Form

Your details

First name

Surname

Address

Suburb

State

Postcode

Mobile

Home phone

Email address

Practice details

Your dental practice name

Your dentist

Type of plan you are cancelling (please tick)

☐ Dental Care Membership Plan ☐ Treatment Membership Plan

Membership number

Reason for cancellation (optional)

Important: I the undersigned do hereby request that my direct debit membership be cancelled, and no further payments be deducted from my specified account. I understand that 14 days notice is required to effect cancellation. I understand that my membership cannot be cancelled while my account is in default. In circumstances where the dental work is not completed the agreed pro-rata amount for the dental work done will need to be paid in a lump sum payment before cancellation of the direct debit.

Members name (please print)

Signature

Date

Please complete form, sign and return to your dental practice for processing.

OFFICE USE ONLY

Practice Administration Staff to sign

Date