CARE Refunds

AUTHORITY TO RELEASE

I …… of ……..……..…. authorise Care Refunds to recover the sum of ……..…… ($.....) to be released by electronic funds transfer to the nominated bank account or by cheque in the name of ……..

I am aware that by authorising Care Refunds to act on my behalf I agree to pay Care Refunds the agreed recovery fee in accordance with the fee agreement.

I authorise Care Refunds and its staff to undertake any necessary searches & procedures required for the recovery of the above funds. I declare that authentic identification document(s) have been provided to Care Refunds and I have read Care Refunds Terms & Conditions and agree to them.

Full Name (Please Print): .....

Signature: .....

Date: .....