REFUND REQUEST FORM – EARLY RELEASE OF SUPERANNUATION

Practice Name: Iconic Smiles Pty Ltd

Practice Address: 183 King Georges Road Roselands, NSW, 2196

Patient Information

Patient Name: _____

Date of Birth: _____

Address: _____

Contact Number: _____

Email: _____

Refund Details

Reason for Refund Request:

_____

_____

_____

Deposit Amount Paid: $_____

Date of Payment: _____

Payment Method: _____

Acknowledgements

1. I understand that submitting this request does not guarantee a refund and that eligibility will be determined by Iconic Smiles based on financial policies and relevant legislation.
2. I declare that the information provided is true and accurate to the best of my knowledge.
3. I understand that if treatment has commenced or materials have been ordered, this may affect refund eligibility.
4. I accept that this information will be provided to the Australian Taxation Office (ATO) in accordance with their guidelines.
5. I understand that in the event of a refund, an administration fee of $1,100 will be charged for processing of documents.
6. I accept that any approved refund may take up to 10 business days to process.

Refund to be made to: (tick one)

[ ] Original Superannuation Fund

[ ] Patient's Personal Bank Account (only if permitted under ATO guidelines)

Bank Details (if applicable)

Account Name: _____

BSB: _____

Account Number: _____

I acknowledge that upon signing this form, I have had the opportunity to ask any questions and acknowledge that this is a legally binding document.

Signature: _____ Date: _____