RESELLER REFERRAL FORM FOR MERCHANT FACILITIES

Date facility required D D M M 2 0 Y Y

REFERRER DETAILS

Business information

Business name

Referrer name

Contact details

Business telephone number

Email address

MERCHANT DETAILS

Business information

Trading name

Contact name

Title Mr/Mrs/Dr/etc. First name

Last name

Contact details

Business telephone number

Mobile number

Email address

ADDITIONAL INFORMATION

Is the Merchant an existing ANZ customer? ☐ Yes ☐ No

Please select the preferred Network: ☐ Worldline ☐ Verifone

Provide a description of the merchant facilities required

INSTRUCTIONS ON COMPLETING THIS DOCUMENT

Completed forms should be returned by email to **resellerleads@anz.com** by clicking on the Submit button below.

A representative from Merchant Business Solutions will contact the Merchant within 8 business hours.

We will keep you updated on the progress of this referral by email and contact you by phone if we need any additional information.

The information contained in this form is confidential to the addressee. If you are not the intended recipient, you are hereby notified that any use, review, dissemination, distribution or copying of the form is strictly prohibited. If you have received this form in error, please notify us on 0800 473 453 and destroy immediately.

By clicking the Submit button, you confirm you have the Merchant's consent to refer their request for merchant facilities to ANZ.

Submit