Consent for Legal Authority

westfund
Health Insurance

Membership Number: ☐☐☐☐☐☐

Member's Full Name: ....

Member's Address: .... **P/Code:** ....

Contact Number: .... **Email:** ....

Third Party Authorisation for

Full Name: ....

Address: ....

.... **P/Code:** ....

Contact Number: .... **Email:** ....

Third party Signature Required: .... Date ..../........../..........
Day Month Year

Declaration

I authorise the above person to act on my behalf and have access to my membership details. This includes health information about me and my dependants that are under 15 years of age which appear on my membership.

I understand that this form and the information it contains may be used by Westfund to manage the personal information that it holds about me.

I know that I can gain access to my information and understand that my information may be disclosed to the person I have authorised to act on my behalf.

I understand that I can withdraw my consent at any time by notifying Westfund in writing of my intention.

I authorise the third party noted above to be given the same rights to operate the membership as I do.
I confirm that the third party will abide by all applicable legislation and Westfund by-laws.

Signature of Member

Member's Full Name (Print) ....

Signature.. Date ..../........../..........
Day Month Year

Signature of Witness

Witness's Full Name (Print) ....

Signature.. Date ..../........../..........
Day Month Year

Please note: The Third Party cannot sign as a witness.

Office use only

Verified by:.. Signature ....

Please tick ✓ the box to confirm this has been noted on the membership: ☐ Date ..../........../..........
Day Month Year