



# MEMBER CONSENT FORM

## AUTHORISATION FOR TRANSMED MEDICAL FUND AND THE ADMINISTRATOR TO DISCLOSE INFORMATION

Please complete this form should you wish to give consent for your or your dependants' medical fund information to be disclosed to a third party. Once the form has been completed, it should be returned to [membership@transmed.co.za](mailto:membership@transmed.co.za). You may also post it to Transmed Membership, PO Box 2269, Bellville 7535. If you require assistance in completing this form, please call **0800 450 010**.

**PLEASE COMPLETE THE FORM IN BLOCK LETTERS.**

**MEMBERSHIP NUMBER**  **(FOR OFFICE USE ONLY)**

### 1. PRINCIPAL MEMBER'S INFORMATION

Title  Initials

Surname

First names

Identity/Passport number  Date of birth

Contact numbers Home:  Work:  Cell phone:

Email address

### 2. TO WHOM MAY INFORMATION BE DISCLOSED?

**My information may be disclosed to:**

My dependant  Yes  No

**or**

Other  Yes  No Please specify: \_\_\_\_\_

**Details of the above, appointed party:**

Title  Initials

Surname

First names

Identity/Passport number

Contact numbers Home:  Work:  Cell phone:

Email address

Relationship

**The above party is the appointed curator/power of attorney**

Yes  
 No

### 3. WHAT INFORMATION MAY BE DISCLOSED?

By ticking the relevant box below, please indicate what information may be disclosed to the party/parties referred to on page 1. Please note that any information relating to the categories below will be disclosed.

- Benefits
- Claims
- Contributions
- All of the above

The time period for which consent will be valid is:  to

**NOTE: If a time period is not specified, the consent will be effective from the date of the signature below and will continue indefinitely thereafter, unless expressly withdrawn by you in writing.**

### 4. CONSENT

I, the undersigned, hereby:

- authorise Transmed Medical Fund and the Administrator to disclose the information to the party/parties, as indicated above;
- agree that neither Transmed Medical Fund nor the Administrator shall be liable for any loss or damage whatsoever, including direct, indirect and consequential damage, that may arise from the disclosure of any information pursuant to this consent;
- agree that once consent is provided, all information selected may be provided to the party/parties; and
- acknowledge that this consent will continue in force until expressly withdrawn by me.

<b>Name of principal member</b>	<input type="text"/>
<b>Signature of principal member</b>	<input type="text"/>
<b>Date</b>	<input type="text" value="DD/MM/YYYY"/>



#### TRANSMED MEDICAL FUND

Customer service department: **0800 450 010**

Email: [membership@transmed.co.za](mailto:membership@transmed.co.za)

Website: [www.transmed.co.za](http://www.transmed.co.za)

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