

third party power of authority consent form

**FEDHEALTH**

Sanlam healthcare partner

E-MAIL TO:
update@fedhealth.co.za**OR MAIL COMPLETED FORM TO:**
Fedhealth Medical Scheme
Private Bag X3045
Randburg
2125Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 100 404
Broker Code: AON001M16**PRINCIPAL MEMBER to complete section 1 to 5. DEPENDANT MEMBER over the age 18 to complete section 6 to 10.**

SECTION 1. PRINCIPAL MEMBER DETAILS

The Principal Member needs to give consent for the disclosure of information on his/her membership to the nominated third party or dependant and the Nominated Party accepts responsibility to protect the Principal Member's personal information.

Membership number													
Title		Initials		Surname					Gender	M	F		
First name(s) (as per ID)					Nationality								
ID or passport number					Date of birth	d	d	m	m	y	y	y	y
Passport number, if no ID					Country of issue of passport								
Income Tax Number					Telephone (H)								
Telephone (W)					Cellular								
E-mail address													

SECTION 2. THIRD PARTY DETAILS

Relationship to principal member													
Title		Initials		Surname					Gender	M	F		
First name(s) (as per ID)					Nationality								
ID or passport number					Date of birth	d	d	m	m	y	y	y	y
Passport number, if no ID					Country of issue of passport								
Income Tax Number					Telephone (H)								
Telephone (W)					Cellular								
E-mail address													

SECTION 3. ADDITIONAL THIRD PARTY DETAILS (IF APPLICABLE)

Relationship to principal member													
Title		Initials		Surname					Gender	M	F		
First name(s) (as per ID)					Nationality								
ID or passport number					Date of birth	d	d	m	m	y	y	y	y
Passport number, if no ID					Country of issue of passport								
Income Tax Number					Telephone (H)								
Telephone (W)					Cellular								
E-mail address													

SECTION 4. ABOUT THE INFORMATION THAT MAY BE GIVEN TO THE THIRD PARTY

Please indicate which information you would like us to provide to your nominated person.

	YES	NO
Personal Information, regarding me and my dependants (Updating and Confirming Personal Details)		
Benefits Information, regarding me and my dependants (Benefit Queries and Claim Queries)		
Financial Information, regarding me and my dependants (Banking Details, Members Portion, Suspension Details, Contribution Details - your chosen third party can only confirm these details, no changes can be done by a third party)		
Medical Information, regarding me and my dependants (Diagnosis, Treatment Plans, Medication, Prescribed Minimum Benefit Guidelines)		
Documents Required, regarding me and my dependants (Statements, Membership Certificates, Tax Certificates)		
All of the above		

SECTION 5. DISCLAIMER

The Principal Member consents that Fedhealth can make the personal information selected in Section 4 available to the nominated party. The Principal Member understands that the nominated party can request and access the selected personal information at any time, until the consent is terminated.

The Principal Member will be responsible for all representations made in terms of this Consent Form. Fedhealth will not be liable for any loss or damages, whether direct or indirect, that may occur as a result of incomplete and/or any incorrect information provided on this Consent Form.

You can access more details on the Protection of your Personal and Health Information on www.fedhealth.co.za.

Signed at..... on this day of 20

Signature of principal member

Print name

Identity number

Signature of third party

Print name

Identity number

(If applicable)

Signature of additional third party

Print name

Identity number

SECTION 6. DEPENDANT MEMBER DETAILS

The Dependant Member needs to give consent for the disclosure of information on his/her membership to the nominated Beneficiary (over the age of 18) and the Nominated Party accepts responsibility to protect the Dependant Member's personal information.

Membership number														
Title		Initials		Surname					Gender	M	F			
Relationship to main member					Dependant code									
First name(s) (as per ID)					Nationality									
ID or passport number					Date of birth		d	d	m	m	y	y	y	y
Passport number, if no ID					Country of issue of passport									
Income Tax Number					Telephone (H)									
Telephone (W)					Cellular									
E-mail address														

SECTION 7. THIRD PARTY DETAILS

Relationship to dependant member														
Title		Initials		Surname					Gender	M	F			
First name(s) (as per ID)						Nationality								
ID or passport number						Date of birth	d	d	m	m	y	y	y	y
Passport number, if no ID						Country of issue of passport								
Income Tax Number						Telephone (H)								
Telephone (W)						Cellular								
E-mail address														

SECTION 8. ADDITIONAL THIRD PARTY DETAILS (IF APPLICABLE)

Relationship to dependant member														
Title		Initials		Surname					Gender	M	F			
First name(s) (as per ID)						Nationality								
ID or passport number						Date of birth	d	d	m	m	y	y	y	y
Passport number, if no ID						Country of issue of passport								
Income Tax Number						Telephone (H)								
Telephone (W)						Cellular								
E-mail address														

SECTION 9. ABOUT THE INFORMATION THAT MAY BE GIVEN TO THE THIRD PARTY

Please indicate which information you would like us to provide to your nominated person.		
	YES	NO
Personal Information, regarding myself (Updating and Confirming Personal Details)		
Benefits Information, regarding myself (Benefit Queries and Claim Queries)		
Medical Information, regarding myself (Diagnosis, Treatment Plans, Medication, Prescribed Minimum Benefit Guidelines)		
All of the above		

SECTION 10. DISCLAIMER

The Dependant Member consents that Fedhealth can make the personal information selected in Section 9 available to the nominated party. The Dependant Member understands that the nominated party can request and access the selected personal information at any time, until the consent is terminated.

The Dependant Member will be responsible for all representations made in terms of this Consent Form. Fedhealth will not be liable for any loss or damages, whether direct or indirect, that may occur as a result of incomplete and/or any incorrect information provided on this Consent Form.

You can access more details on the Protection of your Personal and Health Information on www.fedhealth.co.za.

Signed at..... on this day of 20.....

Signature of dependant member

Print name

Identity number

Signature of third party

Print name

Identity number

(If applicable)

Signature of additional third party

Print name

Identity number