Delegation of Authority

Health Partners

Policyholder's details

Member number

Name *(first name)* *(surname)*

Date of birth *(dd/mm/yyyy)*

Address Postcode

Authority

I, *(policyholder's name)*

authorise *(full name)* *(Date of birth)*

of *(address)*

Phone *(home)* *(mobile)*

Relationship to me ☐ partner/spouse ☐ child over 18yo ☐ parent ☐ carer ☐ other *(please specify)*

to make changes or enquiries on the membership including, but not limited to:

a) updating personal details (eg. address, phone number);
b) changing the level of cover;
c) changing the payment method;
d) adding or removing dependant;
e) suspending and reactivating the membership;
f) submitting claims on behalf of any membership (excludes claims submitted via the My Health phone app);
g) make general enquiries about the membership, including dental and optical appointments; and
h) access personal health information such as medical conditions regarding other members covered on that membership.

Please make this authority effective from

This authorisation does not allow the above nominated person to:

- Cancel the membership
- Change the status of the policyholder
- Nominate further delegated authorities
- Access or change passwords for the policyholder's Members Online account.

If the person you are authorising also has Power of Attorney, please attach that certificate to this form.

Policyholder Declaration

- I declare that I am authorised to sign this application.
- I understand that I still have overall responsibility for the membership, including ensuring premiums remain up to date, in addition to the actions of the person I am authorising above.
- I acknowledge the above authorisation is given at my own risk and that I will have no recourse against Health Partners for any acts, omissions or changes made by the authorised person.
- I understand that I can revoke Delegation of Authority from the person authorised above, at any time by contacting Health Partners.

Signature Date