NRMA INSURANCE

Authority form

1. Please complete this form using **black ink** and write within the boxes in CAPITAL LETTERS.
   Mark appropriate answer boxes with a cross. Start at the left of each answer space and leave a gap between words. PLEASE DO NOT STAPLE.
2. Read the declaration and sign all the signature panels you need to.

Section A: I'm applying to

☐ Nominate an authorised person on my policy

☐ Change details of an existing authorised person on my policy

Section B: Your details

Health Policy number

Surname

Given name(s) Initial Title

Residential Address

Postcode

Postal Address (if different from above)

Postcode

Home phone number

Daytime phone number

Mobile phone number

Email address

☐ If you would like to receive your bills (if applicable), payment reminders, tax statements, benefit statements (when available) and be kept up-to-date with the funds news and services via email, please cross this box.

Section C: Policyholder's declaration

I, as the Policyholder, give the authorised person the same rights to operate the policy as I have.

I acknowledge that the authorised person will have the same rights and obligations as I have, including access to health information, however only I will be able to cancel or remove myself from the policy. Authorisation is given at my own risk and I accept I have no recourse against the Fund for any acts or omissions made by the authorised person.

I acknowledge that this authority will remain active on my policy until I contact the fund and request that it be revoked.

I confirm that I must comply with and be bound by the Policy Terms & Conditions and the Fund's Rules and that I will remain fully responsible for the Policy and the actions of the authorised person.

Signature of Policyholder

✗

D D / M M / Y Y

Section D: Authorised person's details

Surname

Given name(s) Initial Title

Residential Address

Postcode

Postal Address (if different from above)

Postcode

Home phone number

Daytime phone number

Mobile phone number

Section E: Authorised person's declaration

To be completed by the authorised person

I am willing to exercise this authority and, I am over the age of 18 years.

I acknowledge that the policyholder retains the right to cancel the policy or remove themselves from the policy.

My relationship to the policyholder is

Signature of authorised person

✗

D D / M M / Y Y

Privacy Notice: The information collected on this from will be primarily used for the purposes of recording the authority on your policy, verifying the identity of the authorised person and for related administrative purposes. The policyholder and the authorised person have a right to request reasonable access to the information that the fund holds about them. To view our privacy policy please visit our website.

Insurance Australia Limited ABN 11 000 016 722 trading as NRMA Insurance distributed NRMA Health Insurance.
NRMA Health Insurance is provided to you by the insurer Bupa Australia Pty Ltd ABN 81 000 057 590 trading as MBF.
As the Insurer, Bupa Australia Pty Ltd is referred to as the 'Fund'. MBFA 0169 06/10

Provided by mbf health