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 required.

SECTION A: I'm applying to

X Nominate an authorised person/organisation on my membership

X Change details of an existing authorised person on my membership

SECTION B: Your details

Bupa membership number

Surname

First name

Initial Title

Date of birth D D M M Y Y

Sex (M/F)

Residential address

Postcode

Mail address *(if different from residential address)*

Postcode

Home phone *(including area code)*

Work phone *(including area code)*

Mobile

Email

SECTION C: Policyholder's declaration

I, as the Policyholder, give the authorised person or authorised organisation the same rights to the membership as I have, subject to:

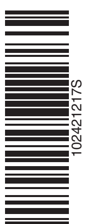
- Only I have the ability to cancel or remove myself from the membership, unless I am on Overseas Visitors cover in which case the authorised person or authorised organisation may cancel or remove me from the membership.
- An authorised person may access my health information, however, an authorised organisation cannot access my health information.

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 or authorised organisation. This authority will remain active on my membership until I contact the fund and request that it be revoked.

I declare that: my typed name stands as my signature for the purposes of this form.

Applicant's signature

Date D D M M Y Y Y Y



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ABN 81 000 057 590

SECTION D: Authorised person's/organisation's details

Authorised person's details
If you would like to authorise a person, please fill in this section.

Surname

First name

Initial Title Date of birth Sex (M/F)

D D M M Y Y

Residential address

Postcode

Mail address *(if different from residential address)*

Postcode

Home number *(including area code)*

Work phone *(including area code)*

Mobile

Email

My relationship to the policyholder is

Authorised organisation's details
If you would like to authorise an organisation, please fill in this section.

Organisation's name

ABN *(if applicable)*

ORGX (organisation identification number)

Contact surname

Contact first name

My relationship to the policyholder is

SECTION E: Authorised person's/organisation's declaration

To be completed by the authorised person/organisation

I, the authorised person, accept the rights and obligations conferred by this authority. If I am being authorised in my individual capacity, then I confirm I am over the age of 18 years and have the capacity to assume the rights and obligations conferred by this authority. If I am accepting this authority on behalf of an organisation, then I warrant that I am authorised and have the capacity to assume the rights and obligations conferred by this authority on the organisation. I acknowledge that **with the exception of Overseas Visitors covers**, only the policyholder retains the rights to cancel the membership or remove themselves from the membership.

I declare that: my typed name stands as my signature for the purposes of this form.

Signature

Date

D D M M Y Y Y Y

PRIVACY NOTE

The information collected on this form will be primarily used for the purposes of recording the authority on your membership, verifying the identity of the authorised person or authorised organisation and for related administrative purposes. The policyholder and the authorised person have the right to request reasonable access to the information that the fund holds about them. To view our Information Handling policy please visit our website, bupa.com.au.

Just before you send

X Check that you have signed all the signature boxes relevant to your application, including the declaration above.
PLEASE DO NOT STAPLE.

Please mail your form to:

Bupa Health Insurance GPO Box 2213 BRISBANE QLD 4001

Alternatively, you can drop by a Bupa Health Insurance store.

If you would like any assistance, please call us on **134 135**.

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Consultant

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