



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



Nominate an authorised person on my membership



Change details of an existing authorised person on my membership

SECTION B: Your details

Bupa membership number

Postal address (if different from home address)

Surname

Postcode

First name

Home phone number (including area code)

Initial Title

Date of birth

Male



Female

Mobile phone number

Home address

Fax number

Postcode

Email address

SECTION C: Policyholder's declaration

I, as the Policyholder, give the authorised person the same rights to operate the membership 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 can cancel or remove myself from the membership.

I acknowledge that on Overseas Visitors covers, the authorised person will have the same rights and obligations as I have, including the ability to cancel or remove myself from the membership.

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 membership 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, Fund Rules or Overseas Visitors Rules and that I will remain fully responsible for the membership and the actions of the authorised person.

Policyholder's signature

Date



