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: What are you applying to do?

☐ I am the policyholder and I want to:

- Nominate an authorised person on my membership/s; or
- Change details of an existing authorised person on my membership/s.

Please complete sections B and C of this form.

☐ I am the policyholder and I want to:

- Nominate an authorised organisation on my membership; or
- Change details of an existing authorised organisation on my membership.

Please complete sections B and D of this form.

☐ I am an insured person, other than the policyholder, and I want to:

- Nominate an authorised person on my membership/s; or
- Change details of an existing authorised person on my membership/s.

Please complete sections B and E of this form.

SECTION B: Your details

Bupa membership number (mandatory)

Surname

First name

Title

Date of birth D D M M Y Y

Male ☐ Female ☐

Residential address

Postcode

Mail address (if different from residential address)

Postcode

Home phone (including area code)

Work phone (including area code)

Mobile phone

Email

SECTION C: Policyholder granting authority to a person

Authorised person's details

Surname

First name

Title

Date of birth D D M M Y Y

Male ☐ Female ☐

Residential address

Postcode

Mail address (if different from residential address)

Postcode

Home phone (including area code)

Work phone (including area code)

Mobile phone

Email

Relationship to the policyholder

1024212175

Bupa HI Pty Ltd
ABN 81 000 057 590

SECTION C: Policyholder granting authority to a person (Continued)

Authorised person's access

Please select whether you would like the authorised person to have Policy Authority, Person Authority, or both.
If you would like to understand the information that these authority types grant access to, please visit our website **bupa.com.au/authority**.

Policy Authority

Please select the level of access you would like the authorised person to have to your policy information. Select one.

☐ **Discuss**
The authorised person can discuss your policy information.

☐ **Change**
The authorised person can discuss and change your policy information.

☐ **Change & Cancel**
The authorised person can discuss and change your policy information, and cancel the policy.

Person Authority

Please select the level of access you would like the authorised person to have to your personal information. Select one.

☐ **Discuss**
The authorised person can discuss your personal information.

☐ **Change**
The authorised person can discuss and change your personal information.

Policyholder's declaration

I, as the Policyholder, give the authorised person access to my membership and/or my personal information based on the level of access I have selected above, subject to:

- Only I have the ability to remove myself from the membership, unless I am on Overseas Visitors cover in which case the authorised person may remove me from the membership.
- Policy Authority includes access to my claims information and the claims information of dependants under 18 years old who haven't chosen to keep their claims information private.

I have obtained consent from the authorised person to share their details on this form. I understand the authorised person will receive communication notifying them that they have been granted authority.

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. 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

SECTION D: Policyholder granting authority to an organisation

Authorised organisation's details

Organisation's name

ABN (if applicable)

ORGX (organisation identification number)

Contact surname

Contact first name

Relationship to the policyholder

Policyholder's declaration

I, as the Policyholder, give the 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 organisation may cancel or remove me from the membership.
- An authorised organisation cannot access my health information.

I have obtained consent from the authorised organisation to share their details on this form.

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 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

1024212175

Bupa HI Pty Ltd
ABN 81 000 057 590

SECTION E: Insured person other than policyholder granting authority to a person

Authorised person's details

Surname

First name

Title

Date of birth D D M M Y Y

Male ☐ Female ☐

Residential address

Postcode

Mail address (if different from residential address)

Postcode

Home phone (including area code)

Work phone (including area code)

Mobile phone

Email

Relationship to the insured person

Authorised person's access

Please note that only the policyholder can grant access to policy information.
If you would like to understand the information that these authority types grant access to, please visit our website **bupa.com.au/authority**.

Person Authority

Please select the level of access you would like the authorised person to have to your personal information. Select one.

☐ **Discuss**
The authorised person can discuss your personal information.

☐ **Change**
The authorised person can discuss and change your personal information.

Insured person's declaration (other than policyholder)

I, as an Insured Person, give the authorised person access to my personal information held by Bupa. The authorised person may discuss or make changes to my personal information based on the level of access I have selected above.

This authorisation does not extend to my claims information.

I have obtained consent from the authorised person to share their details on this form. I understand the authorised person will receive communication notifying them that they have been granted authority.

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. 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

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 Bupa member 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.
PLEASE DO NOT STAPLE.

Please send us your completed form using one of the methods below:

- Message us on WhatsApp: **bupa.com.au/contact-us**
- Login to myBupa and contact live support: **myBupa.com.au**
- Mail your completed form to:
  Bupa Health Insurance GPO Box 4338 MELBOURNE VIC 3001
- Visit your nearest **Bupa Health Insurance store**
- Call us on **134 135**

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Document Name

Consultant

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