LETTER OF AUTHORITY

086 010 4012 | membership@sisonkehealth.co.za | **www.sisonkehealth.co.za**
Administered by Medscheme Holdings (Pty) Ltd. | PO Box 1101, Florida Glen, 1708

SISONKE HEALTH MEDICAL SCHEME
As amalgamated with **Lonmin Medical Scheme**

Please complete electronically.

SUPPORTING DOCUMENTS REQUIRED:

- ☐ A copy of identity document of the person providing authority
- ☐ A copy of identity document of the nominated authorised representative

A. PRINCIPAL MEMBER DETAILS

The Principal Member needs to give consent for the disclosure of information on his/her membership to the nominated third party or dependant. The nominated third party. accepts responsibility to protect the Principal Member's personal information.

Membership number

Title | Initials | First names

Surname

ID/Passport number | Country of issue | Nationality

Date of birth (dd / mm / yyyy) | Gender ◯ Male ◯ Female | Income tax number

Contact details: Home | Work | Cell

Email

B. THIRD PARTY DETAILS

Relationship to principal member:

Title | Initials | First names

Surname

ID/Passport number | Country of issue | Nationality

Date of birth (dd / mm / yyyy) | Gender ◯ Male ◯ Female | Income tax number

Contact details: Home | Work | Cell

Email

C. ADDITIONAL THIRD PARTY DETAILS (IF APPLICABLE)

Relationship to principal member:

Title | Initials | First names

Surname

ID/Passport number | Country of issue | Nationality

Date of birth (dd / mm / yyyy) | Gender ◯ Male ◯ Female | Income tax number

Contact details: Home | Work | Cell

Email

202604

D. INFORMATION THAT MAY BE GIVEN TO THE THIRD PARTY

Please indicate which information you would like us to provide to your nominated third party.

	YES	NO
Personal information, regarding me and my dependants (Updating and confirming personal details)	◯	◯
Benefits information, regarding me and my dependants (Benefit queries and claim queries)	◯	◯
Financial information, regarding me and my dependants (Your nominated third party can only confirm but not change your banking, suspension and contribution details and Member's Portion)	◯	◯
Medical information, regarding me and my dependants (Diagnosis, treatment plans, Prescribed Minimum Benefit guidelines)	◯	◯
Documents required, regarding me and my dependants (Statements, membership certificates, tax certificates)	◯	◯

E. DISCLAIMER

The Principal Member consents that Sisonke Health Medical Scheme can make the personal information selected in Section D available to the nominated third party. The Principal Member understands that the nominated third party can request and access the selected personal information at any time, until the consent is terminated.

The Principal Member will be responsible for all representations made in terms of this Consent Form. Sisonke Health Medical Scheme will not be liable for any loss or damages, whether direct or indirect, that may occur as a result of incomplete and/or incorrect information provided on this Consent Form.

Signed at _____ on this _____ day of _____ 20_____.

Signature of Principal Member

Print name

ID/Passport number

Signature of third party

Print name

ID/Passport number

Signature of additional third party (if applicable)

Print name

ID/Passport number