Delegation of **Authority**

Policyholder's details

Member number

Name *(first name)* *(surname)*

Date of birth *(dd/mm/yyyy)* / /

Address Postcode

Authority

I, *(policyholder's name)*

authorise *(full name)* *(Date of birth / /)*

of *(address)*

Phone *(home)* *(mobile)*

Relationship to me ☐ partner/spouse ☐ child over 18yo ☐ parent ☐ carer ☐ other (please specify)

to make changes or enquiries on the membership including, but not limited to:

- Personal contact details *(eg. address, phone number)*
- Payment method
- Level of cover
- Adding or removing a dependant
- Suspending and reactivating the membership
- Submitting claims on behalf of any member on the membership *(unless otherwise advised; excludes claims submitted via the MyHealth phone app)*
- Accessing claims histories – which could include personal health information such as medical details *(unless otherwise advised; excludes claims histories available via the MyHealth phone app)*
- General information regarding the membership, including items relating to Health Partners Dental and Optical.

Please make this authority effective from / /

This authorisation does not allow the above nominated person to:

- Cancel the membership
- Change the status of the policyholder
- Nominate further delegated authorities
- Access or change passwords for the policyholder's Members Online account.

If the person you are authorising also has Power of Attorney, please attach that certificate to this form *(refer to page 55 of the Health Partners Member Guide for more details about Power of Attorney appointments).*

Policyholder Declaration

- I declare that I am authorised to sign this application.
- I understand that I still have overall responsibility for the membership, including ensuring premiums remain up to date, in addition to the actions of the person I am authorising above.
- I acknowledge the above authorisation is given at my own risk and that I will have no recourse against Health Partners for any acts, omissions or changes made by the authorised person.
- I understand that I can revoke Delegation of Authority from the person authorised above, at any time by contacting Health Partners.

Signature Date / /

Adelaide 101 Pirie Street, Adelaide SA 5000 **Modbury** 27 Smart Road, Modbury SA 5092 **Morphett Vale** 118-120 Main South Road, Morphett Vale SA 5162 **All enquiries** 1300 113 113 **F** 08 8113 2259

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