MEDSHIELD medical scheme

THIRD PARTY CONSENT FORM (LETTER OF AUTHORITY)

Email: membership@medshield.co.za

Please complete in black ink. Print clearly using capital letters. Only one character per block. Leave one block between words.
Mark with a tick where required. All sections must be completed.

ABOUT THE INFORMATION WE PROVIDE TO THE THIRD PARTY

This form needs to be completed if you want to nominate someone to manage your medical aid membership on your behalf. For instance your financial adviser/broker or a family member or a friend who you trust to administer your membership. We call this giving a Third Party Consent by nominating them on this form. This form provides us with your approval that the Scheme may share specific personal information and/or discuss your membership with the specific Third Party you nominated below.

Additonally, please specify what type of information may be accessed by your financial adviser, employer representative and/or nominated Third Party, and for how long (if no date is specified, the consent will be in effect from the signature date until you revoke the consent in writing).

SECTION A — PRINCIPAL MEMBER DETAILS (attach copy of ID)

Membership Number:

Title: Initials:

Principal Member Name/s:

Principal Member Surname:

Principal Member ID number:

E-mail Address:

SECTION B — FINANCIAL ADVISER/BROKER (If applicable)

Your Financial Adviser/Broker ☐

Broker code:

Financial Adviser/Brokerage Name:

Financial Adviser Email address:

Financial Adviser Telephone Number (W):

I, the Principal Member, hereby grant permission, with the consent of all my registered dependants, that my Financial Adviser/Broker as indicated above may have access to:

Type of Information	Yes	No	Date from	Date to
Personal Information: (Membership number, date of birth, ID/passport number, postal, physical and e-mail address, cellular number, phone number, payroll number)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Benefits: (Benefit option, available benefit limits, available savings, waiting periods)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Financial Information: (Banking details, contributions, tax certificate)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Medical Information: (Chronic conditions, Prescribed Minimum Benefits, claims transaction history, treatment plans, authorisations)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Scheme Documents/Forms: (Statements, certificate of membership, application form(s))	Y	N	DD/MM/YYYY	DD/MM/YYYY
Request changes and updates on my behalf	Y	N	DD/MM/YYYY	DD/MM/YYYY

SECTION C — EMPLOYER REPRESENTATIVE (If applicable)

Your employer representative (if you form part of a group membership by virtue of employment) ☐

Company Name:

Employer Representative Name and Surname:

Employer Representative Email address:

Employer Representative Telephone Number (W):

I, the Principal Member, hereby grant permission, with the consent of all my registered dependants, that my employer representative as indicated above may have access to:

Type of Information	Yes	No	Date from	Date to
Personal Information: (Membership number, date of birth, ID/passport number, postal, physical and e-mail address, cellular number, phone number, payroll number)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Benefits: (Benefit option, available benefit limits, available savings, waiting periods)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Financial Information: (Banking details, contributions, tax certificate)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Medical Information: (Chronic conditions, Prescribed Minimum Benefits, claims transaction history, treatment plans, authorisations)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Scheme Documents/Forms: (Statements, certificate of membership, application form(s))	Y	N	DD/MM/YYYY	DD/MM/YYYY
Request changes and updates on my behalf	Y	N	DD/MM/YYYY	DD/MM/YYYY

SECTION D — THIRD PARTY NOMINEE (Another adult that you choose to administer your membership on your behalf or an executor of a deceased estate)

DOCUMENT CHECKLIST

For third party nomination and consent, please attach the below documents	Please Tick
ID copy(ies) of Principal Member and/or person giving consent	
ID copy(ies) of your nominated Third Party	
Death certificate (in the event of the death of a member)	
Executor appointment letter (in the event of the death of a member)	
ID copy(ies) of executor/s (in the event of the death of a member)	

Third Party Nominee 1 ☐

Relationship to Principal Member:

Title: Initials:

First Name/s:

Surname:

ID Number:

Date of Birth: D D M M Y Y Y Y

Email Address:

Telephone Number (W):	C	O	D	E							
Telephone Number (H):	C	O	D	E							
Cell Number:											
Gender: (Mark with an X)	M	F									

I, the Principal Member, hereby grant permission, with the consent of all my registered dependants, that my nominated Third Party as indicated above may have access to:

Type of Information	Yes	No	Date from	Date to
Personal Information: (Membership number, date of birth, ID/passport number, postal, physical and e-mail address, cellular number, phone number, payroll number)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Benefits: (Benefit option, available benefit limits, available savings, waiting periods)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Financial Information: (Banking details, contributions, tax certificate)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Medical Information: (Chronic conditions, Prescribed Minimum Benefits, claims transaction history, treatment plans, authorisations)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Scheme Documents/Forms: (Statements, certificate of membership, application form(s))	Y	N	DD/MM/YYYY	DD/MM/YYYY
Request changes and updates on my behalf	Y	N	DD/MM/YYYY	DD/MM/YYYY

Third Party Nominee 2 ☐

Relationship to Principal Member:											
Title:					Initials:						
First Name/s:											
Surname:											
ID Number:											
Date of Birth:	D	D	M	M	Y	Y	Y	Y			
Email Address:											
Telephone Number (W):	C	O	D	E							
Telephone Number (H):	C	O	D	E							
Cell Number:											
Gender: (Mark with an X)	M	F									

SECTION E YOUR LEGAL DECLARATION

1. I acknowledge and understand that this document authorises Medshield Medical Scheme and its outsourced providers to disclose and/or distribute the above information to the nominated third party(s)/employer representative/financial adviser, if any indicated herein.
2. I agree that by making this information available, Medshield Medical Scheme and its outsourced providers accepts no liability whatsoever for any loss, including direct, indirect and consequential loss, that may arise from the use of this information other than where it is due to, or attributable to, gross negligence or fraudulent conduct by the Scheme.
3. I understand that the consent provided to Third Party(s) will be in force during the specified time periods. If I have not specified the dates, the consent will be in effect from the signature date below until I revoke the consent in writing.

4. Confirm that if I am part of a group membership by virtue of employment, the consent granted to my employer representative will cease when my employment with the company comes to an end. I hereby agree to inform Medshield Medical Scheme immediately of any employment changes.
5. The consent granted to my financial adviser (if applicable) will become null and void in the event that I appoint a new financial adviser.
6. This consent will become null and void in the event of the death of a member or person providing consent, and a new consent form should be completed by the appointed executor of the deceased estate.
7. I may choose to change or revoke my consent at any time by informing the Scheme in writing.

Signed at: ______________________________ Date: | D | D | M | M | Y | Y | Y | Y |

Signature of Person Giving Consent: ______________________________

Name of Person Giving Consent: | | | | | | | | | | | | | | | | | | | | |