



Authorisation for access to my policy

Please complete and return this authority to Southern Cross Health Society if you wish to authorise access to your policy by another individual (including other members on your policy).

Policyholder's name _____ Membership number

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Address _____
Street number Street Suburb Town/city

Date of birth _____ Phone

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 Mobile phone

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E-mail _____

I authorise

Person's name _____ Company name _____

Relationship to policyholder _____

Address _____

Date of birth _____ Daytime phone

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 E-mail _____

I authorise _____ to:

(please tick where applicable)

have access to my policy until notified otherwise by me; or

have access to my policy until ____/____/____

Authorisation

I understand that by making this authorisation Southern Cross may collect and disclose information relevant to the purposes already advised to me under my policy to and from the above named person, and I authorise the above named person to collect and disclose such information on my behalf.

Signed _____ **Date** ____/____/____

- Please return this authority to Southern Cross by either;
- faxing to 0800 379 844; or
 - posting to Southern Cross Medical Care Society, Private Bag 99934, Newmarket, Auckland 1149.