

CONSENT FORM



AUTHORISATION FOR ANGLO MEDICAL SCHEME AND THE ADMINISTRATOR TO DISCLOSE INFORMATION

How to complete this form

- Please use one letter for each block, complete with black ink and print clearly.
- To avoid administration delays, please make sure this form is completed in full.
- Once it is completed, please fax the form to **011 539 1015** or email it to **member@angloms.co.za** or post it to **PO Box 652509, Benmore, 2010.**

YOUR DETAILS

Member Number

First name(s)

Surname

ID Number

TO WHOM INFORMATION MAY BE SUPPLIED

Providers of service Yes No Beneficiaries – registered dependants Yes No

Please specify who

Initials and Surname

Relationship ID Number

Initials and Surname

Relationship ID Number

Other: Please specify who

Initials and Surname

Relationship ID Number

WHAT INFORMATION CAN BE DISCLOSED

Please indicate which information may be disclosed to the party/parties referred to above. Please note that any information relating to the categories below will be disclosed

Benefits Yes No

Financial Yes No

Medical Yes No

Note: If a time period is not specified, the consent will operate from the date of the signature below and will continue thereafter indefinitely unless expressly withdrawn by you in writing.

Time period for which consent will be valid: to

CONTACT DETAILS OF MAIN MEMBER

Full name(s)

Email

Contact number

CONSENT

I, the undersigned, hereby:

- authorise Anglo Medical Scheme and the Administrator to disclose the information to the party/parties as indicated above;
- agree that neither Anglo Medical Scheme nor the Administrator shall be liable for any loss or damage whatsoever, including direct, indirect and consequential, that may arise from the disclosure or any information pursuant to this consent;
- agree that once consent is provided, all information selected may be provided to the party/parties;
- acknowledge that this consent will continue in force until expressly withdrawn by me.

Signed at on this day of 20

Name of person giving consent

Signature of person giving consent