

Authority - consent for legal authority

Member

Membership Number: _____

Member's Full Name: _____
First / Middle / Surname

Member's Address: _____ P/Code: _____

Authorise

Third Party

Third Party Full Name: _____
First / Middle / Surname

Third Party's Address: _____ P/Code: _____

Relationship to member: _____

Declaration

I authorise the above person to act on my behalf and have access to my membership details. This includes health information about me and my dependants that are under 15 years of age which appear on my membership.

I understand that this form and the information it contains may be used by Westfund to manage the personal information that it holds about me.

I know that I can gain access to my information and understand that my information may be disclosed to the person I have authorised to act on my behalf.

I understand that I can withdraw my consent at any time by notifying Westfund in writing of my intention.

I authorise the third party noted above to be given the same rights to operate the membership as I do. I confirm that the third party will abide by all applicable legislation and Westfund by-laws.

Signature of Member

Member's Full Name (Print): _____

Signature: Date: ____/____/____
Day Month Year

Witness

Witness's Full Name (Print): _____

Signature: Date: ____/____/____
Day Month Year

Office Use Only

Verified by: _____

Signature: Date: ____/____/____
Day Month Year

