

**Please note: An Authority to Operate a Membership is required where a person would like someone else to act on their behalf when dealing with Territory Health Fund. This Authority is not required for a spouse or partner if they are covered under the same policy as these permissions exist automatically. This Authority can be used to appoint an Authorised Person/s to access personal and claims information for persons who are aged 16 years and above.**

**Your Details**

Full Name: \_\_\_\_\_ Membership No: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Mobile: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

Postal Address: \_\_\_\_\_

I authorise the following person/s to operate this membership. I understand that this includes requesting policy details and other information, changing or updating policy details and submitting and accessing claims information. Exceptions are removing a person/s from the policy or ceasing the policy itself. I will contact Territory Health Fund directly to remove any authorised parties who I no longer want acting on my behalf.

Member Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Authorised Person 1**

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Member: \_\_\_\_\_ Mobile: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

Postal Address: \_\_\_\_\_

I understand that once this Authority to Operate is in effect, I can contact Territory Health Fund, verify my identity using my details and access information on the Member above. I will keep my details up to date at all times so that I am easily identifiable and contactable if required.

Authorised Person Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Authorised Person 2**

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Member: \_\_\_\_\_ Mobile: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

Postal Address: \_\_\_\_\_

I understand that once this Authority to Operate is in effect, I can contact Territory Health Fund, verify my identity using my details and access information on the Member above. I will keep my details up to date at all times so that I am easily identifiable and contactable if required.

Authorised Person Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_