

Locked Bag 23 Wollongong NSW 2500
Phone: 1800 027 299
Fax: 1300 309 704
Email: info@myrbhs.com.au
Web: www.myrbhs.com.au



Third Party Authority Form

Completing this form authorises the Authorised Person to deal with the Reserve Bank Health Society on behalf of you and the other persons included in the policy in all aspects of the membership. The Authorised Person will have full access to the cover and be able to do all the things that you can do with the membership. The Authorised person will have access to the Personal and Sensitive Information that has been provided through membership with the Reserve Bank Health Society of you and anyone else included on the policy.

Privacy Statement

The personal information of the Authorised Person that is collected on this form will primarily be used for the purposes of recording their authority on the membership, verifying their identity and for related administrative purposes. The Authorised Person will have access to all of the personal and sensitive information of the Member and of anyone else included on the policy that has been provided through membership with the Reserve Bank Health Society. The Member and the Authorised Person have the right to request reasonable access to the information that the Reserve Bank Health Society holds about them. The Reserve Bank Health Society's Privacy Policy can be viewed at: <https://www.myrbhs.com.au/privacypolicy>.

Member Details

Member Number:
Member Name:
Date of Birth:/...../.....
Address:
.....

Declaration by Member

- I declare to giving my authority to the Authorised Person to deal with the Reserve Bank Health Society on my behalf in all aspects of my membership and acknowledge that I may terminate the granting of this right at any time
- I declare that I have received consent from all other persons included on the Policy to authorise the Authorised Person to deal with the Reserve Bank Health Society on their behalf in all aspects of the membership. They acknowledge and agree to the Authorised Person having access to their Personal and Sensitive Information that has been collected by the Reserve Bank Health Society and I have disclosed the Reserve Bank Health Society's Privacy Policy to them
- I and all other persons included on the Policy acknowledge and agree with the Reserve Bank Health Society's Privacy Policy and Fund Rules
- I declare that the information I have provided is true and correct and understand that there are penalties for giving false or misleading information

Member's Signature..... **Date**.....

Please Note: if the member is under 18 years of age, a Parent or Guardian must sign.

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Authorised Person's Details

Authorised Person's Name:

Date of Birth:/...../.....

Address:

.....

Phone:

Relationship to Member:

Declaration by Authorised Person

- I acknowledge and accept that I have been authorised by the Member to deal with the Reserve Bank Health Society on behalf of them and the other persons included in the policy in all aspects of their membership
- I confirm that I am over the age of 18 years and have the capacity to assume the rights and obligations conferred by this authority
- I acknowledge and agree with the Reserve Bank Health Society Privacy Policy and Fund Rules
- I declare that the information I have provided is true and correct and understand that there are penalties for giving false or misleading information

Authorised Person's Signature..... **Date**.....