Third Party Consent Form

Note: AWP Health & Life SA is the insurer, hereinafter referred to as 'the health insurer'. AWP Health & Life SA is part of the Allianz Partners Group and operates under the Allianz brand.
Please complete this form in **BLOCK CAPITALS**.

I (INSERT NAME), _____ date of birth (DD/MM/YYYY): ___ / ___ / _____ ,
by my signature below authorise the health insurer to discuss and disclose personal and medical data relating to the administration of my insurance cover
(policy number: _____) with the following:

Full name _____

Address

_____

Email address

_____

Phone number COUNTRY CODE _____ AREA CODE _____ _____

Date of birth (DD/MM/YYYY) (if natural person) ___ / ___ / _____

Relationship to you _____

Please note that a separate Third Party Consent Form must be completed for each individual aged 18 years or older covered under your policy who also wishes to consent to the disclosure of personal and medical data relating to the administration of their insurance to third parties. For individuals under the age of 18 covered under your policy, we would ask for your authorisation as the parent/legal representative to provide information to third parties.

If you wish to authorise the release of medical records of any individual under the age of 18 covered under your policy to the third party indicated above, please indicate their name and date of birth below:

Full name _____

Date of birth (DD/MM/YYYY) ___ / ___ / _____

Full name _____

Date of birth (DD/MM/YYYY) ___ / ___ / _____

Full name _____

Date of birth (DD/MM/YYYY) ___ / ___ / _____

This consent is effective immediately and will remain in place until you instruct the health insurer in writing that the consent is revoked or the policy is terminated (whichever is earlier).

FRM-Consent-EN-0126

Member's signature

Date (DD/MM/YYYY) ___ / ___ / _____

Once completed, please return this form to: **client.services@e.allianz.com**
If you have any queries please contact our Helpline on: **+ 353 1 630 1301**