CBHS INTERNATIONAL HEALTH

Please send this form and any additional information to:
Students oshc@cbhscorp.com.au
Workers ovhc@cbhscorp.com.au

If you need help completing this form, call us on:
Students 1300 174 538
Workers 1300 174 538

CBHS Corporate Health Pty Ltd ACN 85 609 980 896

Authority to act form

Note: This authority replaces all previous authorities.

MEMBER DETAILS

CBHS Health Fund membership number

Personal details

Last name

First name(s)

Date of birth / / DD / MM / YYYY

Home address

Street number

Street name

Suburb/town

State/territory Postcode

Postal address

Same as above ○

Street number

Street name

Suburb/town

State/territory Postcode

Contact numbers and email

Home Phone ( )

Mobile*

Email*

○ Please attach a Power of Attorney or supporting letter from a doctor outlining the member's condition(s) and reason why the member is unable to grant authority.

AUTHORISED PERSON'S DETAILS

CBHS Health Fund membership number (if any)

Personal details

Last name

First name(s)

Date of birth / / DD / MM / YYYY

Home address

Street number

Street name

Suburb/town

State/territory Postcode

Postal address

Same as above ○

Street number

Street name

Suburb/town

State/territory Postcode

Contact numbers and email

Home Phone ( )

Mobile

Email

Relationship to member

Period of authority to act

Start date / / DD / MM / YYYY

Expiry date (optional) / / DD / MM / YYYY

Authorised person's declaration

I declare that:

a) I am 18 years or over;
b) I have capacity and authority to act on behalf of the member including authority to manage their membership and access claims information;
c) I acknowledge and agree with CBHS International Health Fund Rules (for Students) and CBHS Corporate Health Fund Rules (for Workers) that apply to the member's policy, and Privacy Policy;
d) I understand this authority will remain in place until I contact CBHS Health Fund to request a change or cancellation;
e) I will promptly notify CBHS Health Fund in writing if I am unable to act as an Authorised Person;
f) the information I have provided is true and complete; and
g) I understand there are penalties for giving false or misleading information.

Privacy statement

Personal information provided on this form will be used for the purposes of recording the authority on the membership. For more information, please see our Privacy Policy at cbhs.com.au/privacy-policy

Full Name

Signature

Date / / D D / M M / Y Y Y Y