AECI®
MEDICAL AID SOCIETY

LETTER OF **AUTHORITY**

Administrators: **Medscheme Holdings (Pty) Ltd www.medscheme.co.za**
PO Box 800, Florida Hills, 1716
Telephone: **0860 00 2103**
E-mail: **aeci@medscheme.co.za**

Supporting documents required:

- ☐ A copy of identity document of the person providing authority
- ☐ A copy of identity document of the nominated authorised representative

SECTION 1: PRINCIPAL MEMBER DETAILS

The Principal Member needs to give consent for the disclosure of information on his/her membership to the nominated third party or dependant and the Nominated Party accepts responsibility to protect the Principal Member's personal information.

Membership number																															
Title					Initials						Gender																			m	f
First name(s) (as per ID)																															
Surname																															
Nationality																															
ID number													Date of birth												d	d	m	m	y	y	y	y
Passport number, if no ID																															
Country of issue of passport																															
Income Tax Number													Telephone (H)																		
Telephone (W)										Cellular																					
E-mail address																															

SECTION 2: THIRD PARTY DETAILS

Relationship to principal member																															
Title					Initials						Gender																			m	f
First name(s) (as per ID)																															
Surname																															
Nationality																															
ID number													Date of birth												d	d	m	m	y	y	y	y
Passport number, if no ID																															
Country of issue of passport																															
Income Tax Number													Telephone (H)																		
Telephone (W)										Cellular																					
E-mail address																															

SECTION 3: ADDITIONAL THIRD PARTY DETAILS (IF APPLICABLE)

Relationship to principal member																															
Title					Initials						Gender																			m	f
First name(s) (as per ID)																															
Surname																															
Nationality																															
ID number													Date of birth												d	d	m	m	y	y	y	y
Passport number, if no ID																															
Country of issue of passport																															
Income Tax Number												Telephone (H)																			
Telephone (W)										Cellular																					
E-mail address																															

SECTION 4: ABOUT THE INFORMATION THAT MAY BE GIVEN TO THE THIRD PARTY

Please indicate which information you would like us to provide to your nominated person.

Information Type	**Yes**	**No**
Personal Information, regarding me and my dependants (Updating and Confirming Personal Details)		
Benefits Information, regarding me and my dependants (Benefit Queries and Claim Queries)		
Financial Information, regarding me and my dependants (Banking Details, Members Portion, Suspension Details, Contribution Details - your chosen third party can only confirm these details, no changes can be done by a third party)		
Medical Information, regarding me and my dependants (Diagnosis, Treatment Plans, Prescribed Minimum Benefit Guidelines)		
Documents Required, regarding me and my dependants (Statements, Membership Certificates, Tax Certificates)		
All of the above		

SECTION 5: DISCLAIMER

The Principal Member consents that AECI Medical Aid Society can make the personal information selected in Section 4 available to the nominated party. The Principal Member understands that the nominated party can request and access the selected personal information at any time, until the consent is terminated.

The Principal Member will be responsible for all representations made in terms of this Consent Form. AECI Medical Aid Society will not be liable for any loss or damages, whether direct or indirect, that may occur as a result of incomplete and/or any incorrect information provided on this Consent Form.

You can access more details on the **Protection of your Personal and Health Information**.

Signed at		on this		day of		20	
Signature of principal member							
Print name							
ID or passport number							
Signature of third party							
Print name							
ID or passport number							
(If applicable) Signature of additional third party							
Print name							
ID or passport number							