

## Third Party Access

Please print in black ink, using capital letters and mark check boxes with an X.

GU Health Membership No.

With this form you can nominate a person to have access to your membership. The nominated person will be able to access information and make changes to your membership, but they can't cancel it. If your spouse/partner is named on the membership he/she automatically has this entitlement. If a Power of Attorney exists, please attach a certified copy of this document.

Please complete the information requested below and send your completed form by:

- Scan and email to [corporate@guhealth.com.au](mailto:corporate@guhealth.com.au); or
- FreePost to GU Health, Reply Paid 2988, Melbourne Vic 8060 (no stamp required)

For assistance or more information call your GU Health Member Relations Team on **1800 249 966** between 8.30am and 5pm (AEST) Monday to Friday or email [corporate@guhealth.com.au](mailto:corporate@guhealth.com.au)

### Section 1: Membership holder's details (the person in whose name membership is held)

Title	Surname	Gender
<input type="text"/>	<input type="text"/>	<input type="text"/> M <input type="text"/> F
Given name	Date of birth	
<input type="text"/>	<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y	
Home address		
<input type="text"/>		
State		Postcode
<input type="text"/>		<input type="text"/>
Work telephone number	Home telephone number	Mobile number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address		
<input type="text"/>		

### Section 2: Nominated person's details

Title	Surname	Gender
<input type="text"/>	<input type="text"/>	<input type="text"/> M <input type="text"/> F
Given name	Date of birth	
<input type="text"/>	<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y	
Home address		
<input type="text"/>		
State		Postcode
<input type="text"/>		<input type="text"/>
Relationship to Membership holder		
<input type="text"/>		
Nominated person's signature	Date signed	
<input type="text"/>	<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y	

### Section 3: Declaration (must be signed)

I declare and acknowledge that I have read and understood GU Health's Privacy Policy. I recognise that this authority will allow the person nominated on this form the same level of access as I have, but they will be unable to cancel the membership. I understand that I may revoke this authorisation at any time by writing to GU Health.

Membership holder's signature	Date signed
<input type="text"/>	<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y