AUTHORITY - NOMINATION BY OVERSEAS VISITORS HEALTH COVER POLICYHOLDER

This form is to be completed by a policyholder who is an adult (aged 18 or over) who wishes to nominate another adult as their authorised representative for the purposes of their policy.

Complete and mail to:
HCF
GPO Box 4242
Sydney NSW 2001
or email:
ovhc_service@hcf.com.au

HCF Membership No.

1 YOUR (POLICYHOLDER'S) DETAILS (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Title | First name | Surname

Postal address

Suburb | State | Postcode | Date of birth (DD MM YYYY)

2 DECLARATION

I declare and confirm that:

(a) I am the policyholder and am aged 18 years or over;

(b) I authorise _____ **(print full name)**, whose details are set out below and who has consented to this nomination, to act as my authorised representative for my policy indefinitely, until such time as I or my authorised representative otherwise notify HCF in writing;

(c) I agree that I will promptly notify HCF in writing in the event that I wish to withdraw this authority at any time;

(d) if any other authority/ies exist in relation to conduct of my membership, then this authority replaces all of those other authorities from the date of this authority and those authorities are revoked;

(e) this authorisation does not affect my ongoing obligations under my policy;

(f) I have notified all other persons covered by my policy of this authority;

(g) the address for all communications will be the postal address indicated on this form of the **[policyholder]** or **[authorised representative]** **(please circle relevant role)** until such time as I or my authorised representative otherwise notify HCF in writing; and

(h) the information provided to HCF is true and complete.

Policyholder's signature
X

Date (DD MM YYYY)

3 DETAILS OF AUTHORISED REPRESENTATIVE (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Title | First name | Surname

Postal address

Suburb | State | Postcode | Date of birth (DD MM YYYY)

Phone - home | Email

4 DECLARATION

I declare and confirm that:

(a) I am aged 18 years or over;

(b) I agree to being nominated by the policyholder and accept responsibility for the conduct of their membership as detailed above on their behalf, including ongoing maintenance, receipt of all communications (where applicable) and the payment of premiums, indefinitely until such time as I or the policyholder otherwise notify HCF in writing;

(c) I agree that I will promptly notify HCF and the policyholder in writing in the event that I reasonably believe that I am no longer authorised to act or no longer wish to act on behalf of the policyholder in accordance with this authority;

(d) I will communicate with and act on behalf of all other persons covered by the policy as provided for by the policy;

(e) the information provided to HCF is true and complete; and

(f) the information provided about me in this form or by any other means will be handled by HCF in accordance with its Privacy Policy which is available at **hcfvisitorhealthcover.com** or by calling **13 68 42** and which explains how I can access and request correction of my personal information, how to complain, how to opt out of direct marketing and the uses and disclosures (including overseas) of my personal information by HCF.

Authorised representative signature
X

Date (DD MM YYYY)

Office Use Only: ID sighted and verified or certified copies received and ID verified Yes ☐ No ☐

The Hospitals Contribution Fund of Australia Limited
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HCF Life Insurance Company Pty Limited
ABN 37 001 831 250 AFSL 236 806

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