

Consent form

AUTHORISATION FOR PICK N PAY MEDICAL SCHEME AND THE ADMINISTRATOR TO DISCLOSE INFORMATION

Please complete this form should you wish to give consent for your medical scheme information to be disclosed. Submit the completed and signed form via email to membership@pnmps.co.za.

PLEASE COMPLETE IN BLOCK LETTERS.

Membership details

Membership number	<input type="text"/>		
Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First names	<input type="text"/>		
ID/Passport number	<input type="text"/>		
Contact numbers	<input type="text"/>	Work	
	<input type="text"/>	Home	
	<input type="text"/>	Cell phone	
Email address	<input type="text"/>		

Details of the appointed party

My information may be disclosed to the appointed party specified below:

ID/Passport number	<input type="text"/>		
Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First names	<input type="text"/>		
Contact numbers	<input type="text"/>	Work	
	<input type="text"/>	Home	
	<input type="text"/>	Cell phone	
Postal address	<input type="text"/>		
	<input type="text"/>	Postal code	<input type="text"/>
Email address	<input type="text"/>		
Relationship	<input type="text"/>		

The above party is the appointed curator/power of attorney ☐ Yes
☐ No
☐ Not applicable

What information may be disclosed?

By ticking the relevant box, please indicate what information may be disclosed to the party/parties referred to on page 1. Please note that any information relating to the categories below will be disclosed.

- ☐ Benefits
- ☐ Claims
- ☐ Contributions
- ☐ All of the above

The time period for which consent will be valid is: to

PLEASE NOTE: If a time period is not specified, the consent will be effective from the date of the signature below and will continue indefinitely thereafter, unless expressly withdrawn by you in writing.

Consent

I, the undersigned, hereby:

- authorise Pick n Pay Medical Scheme and the Administrator to disclose the information to the party/parties, as indicated above;
- agree that neither Pick n Pay Medical Scheme nor the Administrator shall be liable for any loss or damage whatsoever, including direct, indirect and consequential damage, that may arise from the disclosure of any information pursuant to this consent;
- agree that once consent is provided, all information selected may be provided to the party/parties; and
- acknowledge that this consent will continue in force until expressly withdrawn by me.

Name	<input type="text"/>		
Signature	<input type="text"/>	Date	<input type="text" value="DD/MM/YYYY"/>

07/2024