Third party authorisation form

Instruction to authorise a third party to have access to information relating to your policy(ies).

Sovereign Health Care

Please complete the whole form using a ball point pen

Sovereign Health Care and its subsidiary companies comply with the Data Protection Act 1998 and we will store and process any personal data collected by us in our systems in accordance with the provisions of the Act. We are committed to keeping your personal information secure, including sensitive personal information relating to your health or medical conditions. We are not allowed to discuss your policy(ies) with your partner or a relative, unless you give us permission to do so by completing this third party authorisation form.

Policyholder details

Policy number S P

Title

Surname

Forename

Date of birth D D – M M – Y Y Y Y

Telephone

Email

Address

Postcode –

Mobile

Please provide the details of the person you would like to authorise to have access to your policy information.

Person to be authorised

Title

Surname

Forename

Date of birth D D – M M – Y Y Y Y

Telephone

Mobile

Email

Address

Postcode –

To be completed by the policyholder

I, the policyholder, confirm that the information given on this form is true and correct. I authorise Sovereign Health Care and its subsidiary companies to disclose details about my policy(ies) to the person named on this form. This authorisation is given until such time as I notify Sovereign Health Care in writing to terminate it. I understand information about my policy(ies), including claims and treatments received, may be disclosed.

Additionally this authority allows the person named to:
- request information regarding claims and benefit entitlement - request changes to my policyholder details

Signature of policyholder

Date ____/____/____

To be completed by the person to be authorised

I, the authorised person, confirm that the information given on this form is true and correct. I confirm that I am over 18 years of age and resident in the UK.

Signature of person to be authorised

Date ____/____/____

Next steps: Please ensure all sections have been completed and the form has been signed by both the policyholder and the person to be authorised. Then return your completed form in an envelope to Sovereign Health Care, Royal Standard House, 26 Manningham Lane, Bradford BD1 3DN. Please remember to affix the appropriate postage stamps to the envelope.

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