Third party authorisation form

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

Please complete the whole form using a ball point pen

Sovereign Health Care and its group companies comply with the General Data Protection Regulation (EU) 2016/679 and any national laws which relate to the processing of personal information ('Data Protection Legislation') and we will store and process any personal information we collect in accordance with Data Protection Legislation. 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

Title

First name

Surname

Date of birth D D – M M – Y Y Y Y

Telephone

Email

Address

Postcode –

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

Person to be authorised

Title

First name

Surname

Date of birth D D – M M – Y Y Y Y

Telephone

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 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 access and/or amend any aspect of my policy(ies) held.

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, that I am over 18 years of age and resident in the UK. I consent to Sovereign Health Care and its group companies holding my personal data to enable me to have access to and amend the policyholder's policy.

Signature of person to be authorised

Date _____ / _____ / _____

Data Protection For further information on how we maintain the security of your information and your rights in relation to the information we hold about you, please see our privacy policy available on our website or contact us if you require a hard copy.

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, 2nd Floor, West Wing, The Waterfront, Salts Mill Road, Shipley, Bradford BD17 7EZ. Please remember to affix the appropriate postage stamps to the envelope.