GOLDEN ARROW
EMPLOYEES' MEDICAL BENEFIT FUND

CONSENT FORM

AUTHORISATION FOR GOLDEN ARROW EMPLOYEEES' MEDICAL BENEFIT FUND AND THE ADMINISTRATOR TO DISCLOSE INFORMATION

PLEASE COMPLETE IN BLOCK LETTERS

Please complete this form should you wish to give consent for your medical fund information to be disclosed.

Submit the completed and signed form by email to goldenarrowmembership@mhg.co.za.

1. MEMBERSHIP DETAILS

Membership number		
Employee number		
Title		Initials
First names		
Surname		
Identity/Passport number		
Contact numbers		Work
		Home
		Cell phone
Email address		

2. DETAILS OF THE APPOINTED PARTY

My information may be disclosed to the appointed party below:

Title		Initials
First names		
Surname		
Identity/Passport number		
Contact numbers		Work
		Home
		Cell phone
Postal address		
		Postal code
Email address		
Relationship to member		

The above party is the appointed curator/power of attorney

- ☐ Yes
- ☐ No
- ☐ Not applicable

3. WHAT INFORMATION MAY BE DISCLOSED?

By ticking the relevant box below, please indicate what information may be disclosed to the party 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 _____
DD/MM/YYYY DD/MM/YYYY

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will be effective from the date of the signature below and will continue indefinitely thereafter, unless expressly withdrawn by you in writing.

4. CONSENT

I, the undersigned, hereby:

- authorise Golden Arrow Employees' Medical Benefit Fund and the Administrator to disclose the information to the party as indicated above;
- agree that neither Golden Arrow Employees' Medical Benefit Fund 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; and
- acknowledge that this consent will continue in force until expressly withdrawn by me.

Name _____

Signature _____ Date _____
(DD/MM/YYYY)

06/2022

Golden Arrow Employees' Medical Benefit Fund

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