# LETTER OF AUTHORITY (LOA)

Please complete all the relevant sections of this form in BLOCK LETTERS.

**MEMBERSHIP NUMBER**

| | | | | | | | | | | | |
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| SECTION A | PRINCIPAL MEMBER DETAILS |
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**MEMBER'S FIRST NAME**

**MEMBER SURNAME**

**ID NUMBER**

| | | | | | | | | | | | | |
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| | | | | | | | | | | | | |

| SECTION B | REPRESENTATIVE DETAILS |
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**REPRESENTATIVE NAME**

**REPRESENTATIVE SURNAME**

**ID NUMBER**

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**Please note that Medshield requires the following documentation to be sent:**

1. A copy of the principal member's ID document;
2. A copy of ID document for each representative that is allowed to access your membership information;
3. A separate LOA for each representative that is allowed to access your membership information.

I, the undersigned hereby give my nominated representative, full power of attorney and authority to on my behalf conduct any business with Medshield Medical Scheme including, but not limited to:

- Accessing my claims history and details;
- Accessing details of my medical conditions;
- Accessing my membership and payment history;
- Terminating, renewing or compromising my membership of the Scheme.

**Principal member signature** _____ **Date** D D M M Y Y Y Y

**Name and Surname** _____