transmed
MEDICAL FUND

Contact details:
Customer service department 0800 450 010

Email:
membership@transmed.co.za

MEMBERSHIP NUMBER

(FOR OFFICE USE ONLY)

MEMBER CONSENT FORM

AUTHORISATION FOR TRANSMED MEDICAL FUND AND THE ADMINISTRATOR TO DISCLOSE INFORMATION

PLEASE COMPLETE THE FORM IN BLOCK LETTERS.
Please complete this form should you wish to give consent for your or your dependants' medical fund information to be disclosed to a third party. Once the form has been completed, it should be returned to membership@transmed.co.za. You may also fax it to 011 381 2041/42 or post it to Transmed Membership, PO Box 2269, Bellville 7535. If you require assistance in completing this form, please call 0800 450 010.

1. PRINCIPAL MEMBER'S INFORMATION

Membership number

Title | Initials

Surname

First name

Identity/Passport number

Telephone (W) | (H)

Cell number

Email address

2. TO WHOM MAY INFORMATION BE DISCLOSED?

My information may be disclosed to:

My dependant ☐ Yes ☐ No

or

Other ☐ Yes ☐ No Please specify: _____

Details of the above, appointed party:

Title | Initials

Surname

First name

Identity/Passport number

Telephone (W) | (H)

Cell number

Email address

Relationship

The above party is the appointed curator/power of attorney ☐ Yes ☐ No

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3. WHAT INFORMATION MAY BE DISCLOSED?

By ticking the relevant box below, 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: D D M M Y Y Y Y to D D M M Y Y Y Y

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will be effective from the date of the signature below and will continue indefinitely thereafter, unless expressly withdrawn by you in writing.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 Transmed Medical Fund and the Administrator to disclose the information to the party/parties, as indicated above;
- agree that neither Transmed Medical 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/parties; and
- acknowledge that this consent will continue in force until expressly withdrawn by me.

NAME OF PRINCIPAL MEMBER	SIGNATURE OF PRINCIPAL MEMBER	DATE
		D D M M Y Y Y Y