THIRD PARTY CONSENT FORM

Please complete this form in BLOCK CAPITALS.

I, INSERT NAME date of birth: D D / M M / Y Y Y Y

by my signature below authorise Allianz Care to discuss and disclose personal and medical data relating to the administration of my insurance cover (policy number:) with the following:

Full name

Address

Email address

Phone number Country code Area code

Date of birth (if natural person) D D / M M / Y Y Y Y

Relationship to you

Please note that a separate Third Party Consent Form must be completed for each individual aged 18 years or older covered under your policy who also wishes to consent to the disclosure of personal and medical data relating to the administration of their insurance to third parties. For individuals under the age of 18 covered under your policy, we would ask for your authorisation as the parent/legal representative to provide information to third parties.

If you wish to authorise the release of medical records of any individual under the age of 18 covered under your policy to the third party indicated above, please indicate their name and date of birth below:

Full name

Date of birth D D / M M / Y Y Y Y

Full name

Date of birth D D / M M / Y Y Y Y

Full name

Date of birth D D / M M / Y Y Y Y

This consent is effective immediately and will remain in place until you instruct Allianz Care in writing that the consent is revoked or the policy is terminated (whichever is earlier).

Member's signature

Date D D / M M / Y Y Y Y

Once completed, please return this form to: **client.services@allianzworldwidecare.com**
If you have any queries please contact our Helpline on: **+ 353 1 630 1301**

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Allianz Care