

Third Party Consent Form

Please complete this form in **BLOCK CAPITALS**.

I, date of birth: / /

by my signature below authorise Allianz Care and Executive Healthcare Solutions Limited (and any of their affiliates), providers, third party administrators, vendors, consultants to discuss, disclose and exchange personal and medical data relating to the administration of my insurance cover (policy number:) , to the extent such disclosure and exchange is necessary to arrange for my care, treatment, processing and payment of insurance claims and, in general, to carry out services related to my health insurance plan.

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 / /

Full name
Date of birth / /

Full name
Date of birth / /

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

Member's signature _____
Date / /

Once completed, please return this form to: client.services@allianzworldwidecare.com or info@executive-healthcare.com
If you have any queries please contact our Helpline on: +353 1 630 1301 or +254 20 291 0000 or +254 709 337 000 (mobile number).