Permission to Information

I, _____ (Beneficiary Name) Membership Number _____

ID Number _____ hereby grant _____

ID Number _____ permission to **make enquiries on my behalf**, relating to my personal health and medical details, at CMP Medical Aid (CMP).

I understand that he/she **will not be allowed to make any changes to my membership**, or **query anything relating to my bank account details**.

If you wish anyone to **change information on your behalf**, we will require a **Power of Attorney** document.

Please provide details of the person that you have given permission to in the table below:

Mobile Number	
Email Address	
Home Telephone Number	
Business Telephone Number	

The Permission to information is **temporary** and may be changed by the beneficiary at any time. This form **only** relates to queries regarding your membership. **Each Beneficiary must complete a separate form**.

……..	……	……..
Signature of Beneficiary	**Name (In block letters)**	**Date**
……	……	……
Signature of Person Granted Permission	**Name (In block letters)**	**Date**
……..	……	……..
Signature of Witness	**Name (In block letters)**	**Date**