



KeyHealth
MEDICAL SCHEME

CONSENT

This form gives consent to KeyHealth Medical Scheme/its administrator to provide information to a third party. A third party is defined as any person or entity other than the principal member.

1. Principal Member Details

Membership Number																									
Title				Initials				First name																	
Surname																									
ID/Passport number	Y	Y	M	M	D	D											Gender:	Male		Female					
Occupation																									
Telephone - home (code - number)													Cellphone number												
Telephone - work (code - number)																									
E-mail address																									

2. Third Party 1

Relationship to member																														
Title					Initials					First name																				
Surname																														
ID/Passport number	Y	Y	M	M	D	D															Gender:	Male		Female						
Occupation																														
Telephone - home (code - number)											Cellphone number																			
Telephone - work (code - number)																														
E-mail address																														

3. Third Party 2

Relationship to member																					
Title					Initials					First name											
Surname																					
ID/Passport number	Y	Y	M	M	D	D									Gender:	Male		Female			
Occupation																					
Telephone - home (code - number)													Cellphone number								
Telephone - work (code - number)																					
E-mail address																					

4. Information that may be given to the third party

Please indicate which information you would like us to provide to your chosen third party.

	Third Party 1		Third Party 2	
Personal Information (Confirm personal details)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Benefit Information (Benefit queries and claim queries)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Financial Information (Banking details, suspension status, contribution information , amounts owing to the Scheme)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Medical Information (Diagnosis, treatment plans, chronic and other authorisations)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Documents (Statements, membership certificates, tax certificates)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
All of the above	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

5. Disclaimer

1. This document gives KeyHealth and its administrator permission to make certain information available to the named third party/parties.
2. I agree that by making this information available, KeyHealth and its administrator are not responsible for any loss (direct, indirect) as a result of such disclosure.
3. I agree that the named third party/parties receiving this information may not hold KeyHealth or its administrator responsible for any claims which result from the wrong use or disclosure of the information by the named third party/parties.
4. I agree that once I have given permission, KeyHealth or its administrator and the Scheme may give all the information within the selected category to the named third party/parties.
5. This permission will end on the date(s) specified on this form. I understand that if I have not stipulated an end date, consent will remain in force until I give specific instruction to end this consent (or when the purpose of the consent is no longer valid).
6. I guarantee that, to the extent that it may be required by law, I have the necessary consent from my dependants to provide this permission.

Signature of
Principal Member

Date

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Once completed, please e-mail the form to consents@keyhealthmedical.co.za