

Authorised Benefit Recipient Permission



Policy Holder's Details

Member #	Name of Policy Holder:
I _____, give my permission for _____ to be able to claim eligible health expenses on my membership.	
In so doing I understand that this authorised benefit recipient will be receiving benefit payments directly for any eligible claims made on expenses paid by them.	
Signature of Member: X	Date: / /

Contact Details for the Authorised Benefit Recipient

Name:		
Current Address:		
Suburb:	State:	Post Code:
Home Phone:	Mobile:	
Email:		

Please return this form to ACA Health Benefits Fund where it will be kept on file for your convenience until further written instruction to change this arrangement is received. Thank you.