Online Member Services Privacy Consent Form

Dependant's Authority to Release Information

Member #	Name of Policy Holder:

In signing below, I give my consent for my ACA Health Benefits Fund details (including information such as claims paid) being made available through Online Member Services to the Policy Holder. I also understand that in the event this decision should change I must contact ACA Health in writing so that this can be discontinued.

Name:	Date of Birth	Signature (required for spouse/partner and all children 14 years and older)
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Policy Holder's Privacy Trigger Questions

These questions and answers will be used to verify your identity as required. Please use BLOCK letters.

Privacy Trigger Question One

Question: What is your mother's maiden name?

Answer: _____

Privacy Trigger Question Two

A unique question of your choice. (e.g. Q: What is my favourite pet's name? A: Spot.)

Question: _____

Answer: _____

Please return to: ACA Health Benefits Fund to info@acahealth.com.au OR Locked Bag 2014 Wahroonga NSW 2076