GROUP CONSENT FORM

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moto HEALTH CARE
taking care of our own

AUTHORISATION FOR MOTO HEALTH CARE AND THE ADMINISTRATOR TO DISCLOSE INFORMATION

SECTION 1: EMPLOYER DETAILS

Group number

Employer name

SECTION 2: HEALTHCARE ADVISOR'S DETAILS

Title | Initials

First name/s

Surname

Broker house

Personal code | House code

Telephone number | Cell phone number

Email address

Signature of healthcare advisor | Date (DD/MM/YYYY)

Disclaimer: The Scheme will pay the agreed commission to the Scheme's appointed broker only.

SECTION 3: WHAT INFORMATION CAN BE DISCLOSED

Please indicate (with a tick) which information may be disclosed to the party/parties referred to above. Please note that any information relating to the categories below will be disclosed.

Benefits Yes ☐ No ☐ **Financial** Yes ☐ No ☐ **Medical** Yes ☐ No ☐

Time period for which consent will be valid: (DD/MM/YYYY) to (DD/MM/YYYY)

Please note: If a time period is not specified, the consent will be valid until cancelled in writing.

SECTION 4: CONSENT BY EMPLOYER

I, the undersigned, hereby:

- authorise Moto Health Care and the Administrator to disclose the information to the party/parties as indicated above;
- agree that neither Moto Health Care nor the Administrator shall be liable for any loss or damage whatsoever, including direct, indirect and consequential, that may arise from the disclosure or any information pursuant to this consent;
- agree that once consent is provided, all information selected may be provided to the party/parties;
- acknowledge that this consent will continue in force until expressly withdrawn by me.

Signed at | on this the | day of | 20

Name of person giving consent

Designation

Signature of person giving consent | Date (DD/MM/YYYY)