

# Customer Authorisation Form



## To be completed by the Group Secretary

Please complete in black ink using **BLOCK CAPITALS**. Please read carefully before signing.

This form is intended for customers to tell their health insurance provider where they would like to obtain their advice from. You should complete it if you require advice from an intermediary, or you would like to change your current intermediary. Please note that your insurer may contact you to confirm your instructions, and, where appropriate, may also contact your current intermediary to inform them of your instructions.

Please complete **EITHER Option 1 OR Option 2**

### Option 1: Policy Review only - authority to conduct market review

I do not wish to transfer our policy at this stage *(please tick)*  Effective date

I understand that relevant information (excluding medical details) relating to our policy will be sent to the intermediary shown in Section 4 to enable the intermediary to carry out a market review of our policy. For the avoidance of doubt, this is NOT an appointment of this intermediary to act permanently on our behalf.

**This authority is valid for 90 days only from the effective date shown.**

Customer Signature  Job Title  Date

### Option 2: Full Transfer to new intermediary

I wish to transfer our policy to the intermediary shown in section 4 *(please tick)*  Effective date

Please accept this as confirmation of the appointment of the intermediary shown in Section 4 below as the sole intermediary to act on our behalf in relation to our policy. I understand that all information relating to our policy will be sent to the new appointed intermediary, and that this may attract commission for the newly appointed intermediary in line with our insurer's Terms of Business. For the avoidance of doubt this appointment will continue until such time as you are notified, in writing, to the contrary.

Customer Signature  Job Title  Date

## ALL Customers to complete Section 3

### 3: Customer Details

Insurance Company  Customer Signature   
Policy Number  Job Title   
Customer/Group Name  Date   
Customer Postcode  Please print your full name

### 4: Intermediary Details

Intermediary Agency Number  Intermediary signature   
Intermediary Company Name  Date   
Please print your full name

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This form has been produced by AMII (Association of Medical Insurance Intermediaries) and BIBA (British Insurance Brokers Association), with the support of a number of leading health insurance providers.

For a full list of participating insurers, please visit: [www.amii.org.uk](http://www.amii.org.uk) or [www.biba.org.uk](http://www.biba.org.uk)

## Guidance to the intermediary

This Customer Authorisation Form should be completed and signed by your client, and then forwarded to the insurance company together with the following Client Statement, which should be reproduced onto the client's company letter-headed paper.

Both the Client Statement and the Customer Authorisation Form should be completed and signed by the SAME person within the client company, who must be an authorised signatory on the insurance policy.

## Request to insurer statement for reproduction onto client letterheading

To whom it may concern

Date:

Dear Sirs

**RE: Policy Number [please enter your policy number here]**

Please find attached a signed Customer Authorisation Form, which sets out how I wish you to deal with **[enter name of broker / intermediary here]** in respect of the above insurance policy.

I can confirm that **[enter name of broker / intermediary here]** have fully explained both options to me and I have explicitly chosen **Option 1 / Option 2\* (\* delete whichever is not applicable)**

Yours faithfully

Name  
Position  
Company