

Authorisation form

The undersigned

Name:

Date of birth:

Address:

Town/city and postal code:

Policy number:

(hereinafter referred to as “principal”)

hereby authorises

Name:

Date of birth:

Address:

Town/city and postal code:

Relationship with the insured:

(hereinafter referred to as “authorised representative”)

to:

Make enquiries - within the framework of the principal’s healthcare insurance - at HollandZorg by telephone about the contents of the healthcare insurance of the principal and/or about the (financial) correspondence between HollandZorg and the principal and to look after the principal’s interests in that respect.

The principal hereby also authorises HollandZorg to provide his or her personal details, including medical information, to the authorised representative.

This authorisation ends by means of a notice of termination.

Town:

Date:

Signature principal

Town:

Date:

Signature authorised representative

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You can mail the completed form to info@hollandzorg.nl or send it to HollandZorg, Antwoordnummer 30, 7400 VB Deventer by post (no stamp required).