

# Authority Form



Policy Owner(s) or Lives Assured will complete this form if they wish to give authority to an individual. The individual can then act with the permissions specified on this form.

## I/We give authority to:

Mr/Mrs/Miss/Ms/Mx

Full name  
"the authorised person"

Address

Date of birth  
(dd/mm/yyyy)

Email address

Telephone

Home

Work

Mobile

## To act on my/our behalf as Policy Owner(s) or Lives Assured:

### Policy Owner/Life Assured

Mr/Mrs/Miss/Ms/Mx

Policy Owner/  
Life Assured's full name

Address

Date of birth  
(dd/mm/yyyy)

Email address

Telephone

Home

Work

Mobile

### The authorised person is allowed to:

- |  |                          |     |                          |    |
|--|--------------------------|-----|--------------------------|----|
| Change my contact details  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Change my payment method and/or frequency                                | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Obtain my policy information<br>(excludes claim and medical information) | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Obtain my claims information   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Obtain my medical information  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

### Joint Policy Owner (if applicable)

Mr/Mrs/Miss/Ms/Mx

Joint Policy Owner's full name

Address

Date of birth  
(dd/mm/yyyy)

Email address

Telephone

Home

Work

Mobile

**To act on my/our behalf as Policy Owner(s) or Lives Assured: Continued...**

**The authorised person is allowed to:**

Change my contact details	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Change my payment method and/or frequency	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Obtain my policy information (excludes claim and medical information)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Obtain my claims information	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Obtain my medical information	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

**This authority applies to:** all policy/plan number(s)  Yes or, only applies to:

**This authority is valid:** until further notice  Yes or, until:

- > I/We acknowledge that I/we are responsible for ensuring that the authorised person consults with me/us and obtains my/our approval as appropriate in relation to any actions taken under this Authority.
- > I/We acknowledge the authorised person can only change my/our payment details to a bank account or credit card they are authorised to operate.
- > In consideration of AIA acting upon my/our instructions I/we undertake to indemnify and hold harmless AIA from and against any and all claims, losses, damages, cost and expenses, which AIA may suffer or incur.
- > I/We understand that all other processes/requests/changes to the policy require the authorisation of the policy owner(s).
- > I/We acknowledge and understand that the authorised person in their dealings with AIA will be bound by the terms and conditions of the applicable policy document(s) for the policy(s) stated on this Authority form.
- > The Authority form is no longer valid if I/We or the authorised person is determined to be no longer competent to manage their own affairs in relation to their property.
- > Throughout this document, "I/We" refers to the policy owner(s)/life assured granting this authority; "authorised person" refers to the holder of this authority".
- > I/We have obtained the authorised person's consent to provide their information contained in this form.
- > The personal information provided by me/us will only be used by AIA to administer this Authority Form, including processing any request made under this Authority Form. The information provided will be held at AIA's offices at 74 Taharoto Road, Takapuna, Auckland 0622. AIA also uses third party data storage providers, including related companies and cloud-based data storage providers in New Zealand and overseas. I/we have the right to request access to, and correction of, any of the information provided at any time.

**Signature of Policy Owner(s) / Life Assured:**

Signature of Policy Owner/Life Assured	X	Date <span style="font-size: small; color: grey;">DD/MM/YYYY</span>	
Signature of Joint Policy Owner (if applicable)	X	Date <span style="font-size: small; color: grey;">DD/MM/YYYY</span>	

