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

Policy Number

Customer/Group Name

Customer Postcode

Customer Signature

Job Title

Date

Please print your full name

4: Intermediary Details

Intermediary Agency Number

Intermediary Company Name

Citrus Healthcare Consulting Limited

Intermediary signature

Date

Please print your full name