



## Member Details

Membership Number: \_\_\_\_\_

I, \_\_\_\_\_  
Title Given Name[s] Surname

of \_\_\_\_\_

\_\_\_\_\_ Address

hereby declare that \_\_\_\_\_  
Title Given Name[s] Surname

of \_\_\_\_\_

\_\_\_\_\_ Address

is unable to correspond with Central West Health Cover with regard to any matters relating to his/her policy. I also declare that I am fully responsible for the conduct of the above named person's affairs. Please accept my signature in relation to any matters regarding the above named.

Power of Attorney's Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

This form must be accompanied by an Enduring Power of Attorney document or Doctor's Certificate.