Authority to act

Complete this form to authorise someone to act on your behalf.

1. Your details		
Your name:	Claim number:	
Date of birth:	Email:	
Address:		
Home phone:	Mobile phone:	Work phone:

2. Your nominated person	
Please enter the details of the person you'd like to give authority to act on your behalf.	
Full name:	Relationship to you:
Postal address:	
Business address (if applicable):	
Where would you like us to send your correspondence?	
Email address (if applicable):	Home phone:
Mobile phone:	Work phone:

3. Authority to act	
This authority to act covers (tick one only)	
☐ Specific claim(s) only Please list the claim number(s):	☐ All my claims currently managed by Wellnz

4. Declaration

- I authorise Wellnz to act on the instructions of my nominated person
- I understand that Wellnz is not responsible for any actions of my nominated person using this authority
- I understand that this authority comes into effect from the date Wellnz receives this form
- I understand that I am giving my nominated person authority to access my information by telephone, email and letter
- I understand I can write to or call Wellnz at any time to cancel this authority, and Wellnz will only cancel this authority if I ask them to in this way. Cancellation will not be effective until received by Wellnz.

Signature:	Date:

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When we collect, use and store information, we comply with the Privacy Act 2020 and the Health Information Privacy Code 2020. For further details see ACC's privacy policy, available at www.acc.co.nz. We use the information collected on this form to fulfil the requirements of the Accident Compensation Act 2001.