

Authority to access information



IMPORTANT

Complete all sections of this form to allow a third party to access your account details. Please also attach proof of your identify to this form (e.g. a copy of your passport or driver licence). Complete this form in blue or black pen using BLOCK LETTERS and tick where applicable.

1. YOUR PERSONAL DETAILS

Tick what type of member you are Super member Pension member

Member account number _____ Date of birth (DD/MM/YYYY) _____ Title _____

Surname _____

Given names _____

Residential address (required) _____

Suburb _____ State/territory _____ Postcode _____

Postal address (if different from above) _____

Suburb _____ State/territory _____ Postcode _____

Mobile _____ Daytime telephone _____

Email _____

Gender Male Female

2. THIRD PARTY DETAILS

Name of third party you are appointing _____

Full name of primary contact _____

Third party address _____

Suburb _____ State/territory _____ Postcode _____

Contact telephone number _____



If you're providing authority to a company, please provide a primary contact name in Section 2.

RELATIONSHIP TO YOU Please tick (✓) the appropriate box.

Financial Planner (please provide the name of the financial planning company)

Company name

Full name of primary contact

ABN

AFSL

Family representative/relative name (please specify relationship)

Representative name

Legal representative

Agent

Power of attorney (please provide a copy of your Power of attorney)

Other (please specify)

3. PROVIDE YOUR IDENTIFICATION

To validate you are making this authorisation please attach a copy of ONE of the following:

Your Driver licence

Your passport

Proof of age card

(The copy does not need to be certified.)

4. AUTHORISATION

- I hereby authorise the above-named person (overleaf) to have access to and/or provide information about my CareSuper account.
- I understand that this authority will expire 24 months from the date I sign this form, unless I cancel it in writing.
- By acting on this request, I release CARE Super Pty Ltd (the Trustee) from any liability or responsibility, both now and in the future, due to the release or acceptance of information. I understand that the Trustee can only release information that I, in my personal capacity, am entitled to.
- If you have appointed a financial planner, make sure you've provided a primary contact name in Section 2.

I authorise staff from the company named above to access information about my account. By ticking (✓) yes, I understand that CareSuper will accept and/or release my information to anyone who claims to act for or represent the company named above having first asked for the person I have named.

Yes No

Full name

Member's signature

____/____/_____
Date (DD/MM/YYYY)



YOU MUST PRINT AND THEN SIGN THIS FORM

The form won't be valid if you don't sign it.

ONCE YOU'RE DONE

Return this completed form together with a copy of your proof of identity to:

CareSuper
Locked Bag 20019
Melbourne VIC 3001

For more information call **1300 360 149**.