"We Care"

MEDICAL BENEFITS SCHEME

LETTER OF AUTHORIZATION (A1)

I _____ _____
(Name of Beneficiary) **(MBS Number)**

Authorize the following three (3) persons to collect my medication. **

_____

_____

_____

(Authorized person(s) must be over twelve (12) years old.)**

Signature of Beneficiary: _____ Date: _____

Address: _____

Telephone No.: _____ Cell: _____

Witnessed by: ……
(Print full Name) - ***Authorized persons and the beneficiary cannot witness this form.***

Signature: ……. Date: ……..……..……

Address: ……

Telephone No.: …….. Cell: ……

Please note that there is a verification process to ensure that the information given is correct.

OFFICIAL USE

Processed by: …….. Date: ……..……

Verified by: ……..……. Date: ……..…..……..…