MEDICAL INDEMNITY INSURANCE
THIRD PARTY AUTHORITY

Client ID: _____

Name of Client: _____

Please complete this form if you require other persons (such as your spouse, partner, personal assistant or practice manager) to access personal and other information about you and your insurance (including claims information) and membership and to request and make changes to your insurance.

We must have your written authority to:

- provide personal and other information (other than information detailed under d) “Privacy” on page 36 of the Combined Financial Services Guide & Product Disclosure Statement) about you and your insurance to such persons; and
- accept and action instructions to request and make changes to your insurance from such persons.

Please detail below each person you authorise to access personal and other information about you and to request and make changes to your insurance:

Authorised persons	First person	Second person
Full Name		
Date of Birth		
Relationship to you		
Phone Number		
Email Address		

The person(s) you have identified above will be required to validate your authority whenever they contact Miga by providing their full name, date of birth and relationship to you plus your Miga membership number and principal practice address.

The persons you identify above will be recorded in and remain “Authorised persons” in our system for the purpose of accessing personal and other information about you and your insurance and membership and to request and make changes to your insurance until you provide written instructions to us to withdraw your authorisation(s) or to nominate alternate or additional Authorised Persons.

Please note that you still have a duty to disclose to us every matter which you know, or could reasonably be expected to know, is relevant to our decision to accept the risk of the insurance and, if so, on what terms. You have the same duty to disclose such matters before you renew, extend, vary or reinstate a contract of insurance.

The authority to the persons you identify above does not diminish your Duty of Disclosure under the Insurance Contracts Act (1984).

Signed: _____ Date _____

70 Franklin Street, Adelaide
GPO Box 2048, Adelaide, SA 5001

Free Call 1800 777 156
Facsimile 1800 839 284
Email miga@miga.com.au
Website www.miga.com.au

Medical Defence Association of South Australia Limited ABN 41 007 547 588
Medical Insurance Australia Pty Ltd ABN 99 092 709 629 – AFSL 255 906
Referred to jointly as ‘Miga’

Form date: April 2025