



**DefenceHealth**

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Applicant Surname			
Applicant First name		Title/Rank	
Address			
Suburb		State	Postcode
Daytime phone	Email		

Member No

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### A Email communications

I consent to receiving such future Defence Health correspondence as is available electronically via email rather than by post.

My email address is as noted above.

### B Authorisation

This form must only be signed by the owner of this health insurance policy.

**Name**

**Signature**

**Date**



\* A H B C C 0 0 3 \*

