



EUROP ASSISTANCE HOLDINGS LIMITED PENSION AND LIFE ASSURANCE PLAN
FORM OF AUTHORITY

MEMBER NAME	
NI NUMBER	
DATE OF BIRTH	
ADDRESS	

Details of financial advisor:

COMPANY	
CONTACT NAME	
REFERENCE NUMBER	
ADDRESS	
EMAIL ADDRESS	
TELEPHONE NUMBER	
FAX NUMBER	

I hereby give my explicit authority for the Trustees of the Europ Assistance Holdings Limited Pension and Life Assurance Plan to release information relating to my pension benefits to the person(s) detailed above, until further notice.

Signed: (by the member) Date: