NATIONAL TRANSPORT SUPPORT SERVICES

AUTHORISATION FORM FOR DECEASED

Date:	THF Client No:

CLIENT INFORMATION

Deceased Last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar/Defacto ☐ Div ☐ Sep ☐

Was this their legal name?		If not, what was their name?	(Former name):	Birth date:	Age:	Sex:	
Yes	No					☐ M	☐ F

Street address:	Tax File no.:	Home phone no.:
		( )

P.O. Box:	City:	State:	Post Code:

Occupation:	Employer:	Employer phone no.:
		( )

Spouse/Next of Kin Name	Address	Phone No:
		( )

Authorisation permitted for the following: (Please tick what is applicable.)

☐ All ☐ Employer ☐ Medical ☐ Superannuation ☐ Legal ☐ Financial ☐ Insurance ☐ Legal ☐ WorkCover ☐ Child Support

NEXT OF KIN AUTHORISATION INFORMATION

Name	Birth date:	Address (if different):	Home phone no.:
			( )

Relationship to Deceased:	☐ Spouse	☐ Parent	☐ Child	☐ Other	

ADDITIONAL INFORMATION

Employer No:	WorkCover No:	TWU No:	Superannuation No:	Insurance No.:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to Client:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorise a representative of the Trans-Help Foundation Ltd to make enquiries, obtain information and act on my behalf in the same capacity as myself. This includes obtaining documentation, information, liaising on my behalf and representing me. If this authority is to be revoked it will be in writing to any agency in which this authorisation has been supplied to. I understand that all information obtained will be held in the custody of the Trans-Help Foundation and at any time I can request all documentation including a list of agencies this authorisation has been supplied to. I also understand and agree that any costs incurred by any Agency will be my responsibility and not that of the Trans-Help Foundation. I also understand that no action will be taken by the Trans-Help Foundation that could result in a financial cost without liaising with me for consent to proceed with such action.

Client / Guardians Name		*Representatives Name*	

Date / /

Date / /

This form is to be completed and forwarded to the Trans-Help Foundation, P.O. Box 141, Tarcutta, NSW 2652 or faxed to 02 69287004, alternatively a scanned copy of the document can be emailed to admin@transhelpfoundation.com.au