

To the Agency Team

Provider:

Date:

Re: **PRIVATE HEALTHCARE SCHEME**

POLICY / SCHEME NUMBER:

POLICY / SCHEME NAME:

CONSULTANT'S NAME:

PROVIDER'S AGENCY CODE:

Annual Premium £..... **Renewal Date:**

Letter of Authority (for reviews and quotations)

We wish to confirm our permission for Chartwell Healthcare Limited to receive information on the above Healthcare Scheme on a third party basis. Please therefore provide them with any information that they may request.

We understand that this does not entitle Chartwell Healthcare Limited to receive any outstanding commission on the Scheme.

Please confirm this request has been actioned, by contacting me on the details below: -

Telephone Number: 0117 917 1966 or Email: chartwellhealthcare@chartwellhealthcare.co.uk

Yours sincerely

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Scheme Administrator / Authorised signatory

Print Name & Title: Mr/Mrs/Ms:

Capacity: