



Processing ID

Arrival date

**I AUTHORISE THE FOLLOWING PERSON**

Authorised person's surname and forenames

Identity number

Address, line 1 (building, street, etc.)

Postal code and city

Telephone (also dialling prefix)

E-mail address

**TO MANAGE THE PHARMACEUTICAL INJURY MATTER ON MY BEHALF**

Processing ID (if known)

Compensation from the pharmaceutical injury insurance shall be paid in to (select one)

the bank account of the authorised person

the bank account of the patient or other claimant

the bank account of the trustee (provider or guardian) of the underage or other minor party

Account number, in IBAN format

Account-holder's name

**PLACE, DATE, AND SIGNATURE**

Place and date

Authoriser's signature and printed name

**WITNESSES**

First witness' signature

Second witness' signature

Printed name

Printed name