MINISTRY OF HEALTH
SINGAPORE

REVOCATION FORM FOR
MEDICAL CLAIMS AUTHORISATION (MULTIPLE INSTITUTIONS)

Central Provident Fund Board Singapore

I - Particulars of Account Holder & Insured (as in NRIC/other identification document)		
Name:	Date of Birth: (DD-MM-YYYY)	☐ Singapore Citizen ☐ Permanent Resident ☐ Foreigner
NRIC / CPF Account No:	FIN / Passport No: (for foreigners only)	
Email Address: (optional) *Please provide your email if you would prefer to receive the acknowledgment letter via email*		

Please also complete Part II below if you are not the Account Holder & Insured:

II - My Details (as in NRIC/other identification document)

My Name(s):	My NRIC/FIN/Passport Number(s):

I am signing this form on behalf of the Account Holder & Insured as (please tick):

☐ **The parent / legal guardian[@] of the Account Holder & Insured who is under 21 years of age.**
- Please provide a copy of your NRIC / passport and the Account Holder & Insured's birth certificate / NRIC.
- Please note that the consent will expire once the Account Holder & Insured reaches 21 years of age.

☐ **Donee(s) acting under a Lasting Power of Attorney** registered under the Mental Capacity Act (Cap.177A) **("MCA") with power to act on behalf of the Account Holder & Insured; or**
Deputy(s) appointed by the Court under the MCA to act on behalf of the Account Holder & Insured.
- Please provide a copy of your NRIC / passport and the Registered Lasting Power of Attorney / Order of Court.
- Please check whether you may act singly or jointly with other donee(s)/deputy(s).

[@] You are lawfully appointed as a legal guardian by a court or under a will/deed.

Note: Capitalised expressions have the same meanings assigned to them in the Medical Claims Authorisation Form (Multiple Institutions) ["MCAF(M)"]. You may request for a copy of your signed MCAF(M) from the Administrator.

1. I had previously authorised CPF Board and my Insurer to withdraw from my MediSave and claim from my Health Insurance Policy as needed, to pay for my medical treatment charges at Participating Medical Institutions. I had also allowed the Government and its appointed agencies, the CPF Board, my Insurer and its appointed agencies, Participating Medical Institutions, and healthcare professionals at any medical institution who have cared for me to collect, share and use my Healthcare Information for the purposes stated in paragraph 3 below.

Revocation of Consent & Authorisation

2. I hereby revoke my consent and authorisation previously given through the signed MCAF(M).
3. I agree that it may take up to 7 working days from the date the Government (or the Government's appointed administrator) receives this form for this revocation to be effective. Once this revocation takes effect, the Government and its appointed agencies, CPF Board, my Insurer and its appointed agencies, Participating Medical Institutions, and healthcare professionals at any medical institution who have cared for me may no longer collect, share, or use my Healthcare Information:
   (a) to check my MediSave and Health Insurance Policy information in order to facilitate my Claims;
   (b) to process and administer my Claims;
   (c) to assess and audit my Claims and adjudicate Claims-related disputes; and
   (d) for data analysis, evaluation and policy-making and review by the Government and CPF Board (except when my Healthcare Information is used in such a way that I am not identifiable as an individual).

Exceptions

4. I understand that this revocation will not apply to any consent and/or authorisation which may have been provided by me through any other form apart from the MCAF(M).
5. I accept that this revocation will only apply to future Claims. My previous consent and authorisation will still apply to any Claims submitted before this revocation becomes effective.
6. I understand that this revocation shall not operate to affect, restrict, or limit any right of the Government and its appointed agencies, CPF Board, my Insurer and its appointed agencies, Participating Medical Institutions, and healthcare professionals at any medical institution who have cared for me to collect, share, and use my Healthcare Information where permitted or required by law.

Signature / Thumbprint of Account Holder & Insured / Person signing on behalf of Account Holder & Insured	Date of Signature (DD-MM-YYYY)
Interpreted by (Name & NRIC):	

Signature of Witness	Date of Signature (DD-MM-YYYY)
Name of Witness:	
NRIC / Official Stamp:	

Instructions

A. Please submit the completed form to:

The MCAF administrator email: mohh.mcaf@mohh.com.sg

Or

The Participating Medical Institution staff who gave you this form.

B. Alternatively, you may also return the completed form to:

Attn: MCAF Administrator

Bukit Merah Central Post Office, P.O. Box 680, Singapore 911536

C. Should you have any queries about this form, please contact the MCAF Administrator at mohh.mcaf@mohh.com.sg.