POWER OF ATTORNEY DECLARATION

Account Number(s)			
1. CUSTOMER DETAILS (DONOR - THE ACCOUNT HOLDER)			
Full Name:		Date of Birth:	
Address:			
Town:			
Postcode:			
2. ATTORNEY(S) DETAILS (HAVING POWER UNDER THE POA)			
Full Name:		Full Name:	
Address:		Address:	
Town:		Town:	
Postcode:		Postcode:	
3. AUTHORISATION DETAILS			
Please tick here if the Attorney(s) agree that the Customer/Donor is mentally capable of managing their own affairs and may give instructions to us in addition to the Attorney(s)			
4. DECLARATIONS AND SIGNATURE OF ATTORNEY - WE RECOMMEND THAT YOU TAKE LEGAL ADVICE BEFORE SIGNING THIS DECLARATION			
 I/We the named Attorney(s) confirm and agree: Where I/We attach a Lasting Power of Attorney, it has been registered at the Office of the Public Guardian. I/We have provided Principality with the original or certified copy of the Power of Attorney. Where I/we attach an Enduring Power of Attorney, I/we confirm that the Donor has not lost mental capacity, nor is in the process of doing so. Alternatively, if the Donor has lost mental capacity, or is becoming mentally incapable, I/we have registered the Enduring Power of Attorney at the Office of the Public Guardian. I/We are legally required to act on behalf of the customer/donor in relation to their Property and Financial affairs and I/We will do so in their best interest and for their benefit. I/We will notify Principality immediately if the Power of Attorney is amended or ceases to be valid. I/We declare that information I have provided with this form is true complete and accurate. 			
5. SIGNATURE(S) OF ATTORNEY(S)			
Where the POA is held jointly both Attorneys must sign the form before we can register it.			
Where the Attorneys hold the POA severally (or jointly and severally), the Attorney who intends to operate the account at the time of completing this form must sign. (If this changes a new form will need to be completed)			
Signature:		Signature:	
Print Name:		Print Name:	
Dated:		Dated:	
For official use only			
Staff Name:			
Date:			



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