

## IDENTIFICATION

Name of claimant: \_\_\_\_\_

Policy No: \_\_\_\_\_ Date of birth: \_\_\_\_\_ day / month / year

To assess and determine my eligibility with respect to insurance products and benefits, I hereby authorize any physician, health professional, hospital, medical establishment, insurance company, the Medical Information Bureau (MIB) or other organization, institution, employer, broker, agent, representative or other individual in the possession of information about me or my state of health, including my medical history, to convey or transmit this information to Canassurance Hospital Service Association or Canassurance Insurance Company (hereinafter referred to as the 'Insurer'), or reinsurer, internal or external auditors, as well as any professional or organization mandated by the Insurer for the purpose of processing of my claim.

I hereby authorize Canada Pension Plan (CPP), Québec Pension Plan (QPP), Human Resources and Skills Development Canada (HRSDC), Commission de la santé et de la sécurité du travail du Québec (CSST), Workplace Safety and Insurance Board of Ontario (WSIB), Régie de l'assurance maladie du Québec (RAMQ), Société de l'assurance automobile du Québec (SAAQ) and any other federal or provincial organization or board to convey to the Insurer administrative, medical and pharmacological information about me.

In addition, I hereby authorize the Insurer to share information about me with the aforementioned individuals and organizations. This authorization shall be valid for the duration of my disability.

Signature of claimant \_\_\_\_\_ Date: \_\_\_\_\_ day / month / year

01QRI0037A

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