



Authorization

IDENTIFICATION

Name of claimant: _____

Policy No: _____ Date of birth: _____ day / month / year

Name of policyholder: _____

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 or reinsurer, the MIB, Inc. 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 Insurance Company and/or Blue Cross Life Insurance Company of Canada, hereafter called 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 des normes, de l'équité, de la santé et de la sécurité du travail (CNESST)*, 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 claim. By sending us this form, you understand that we will process your personal information in accordance with the terms of our Privacy Policy available on our web site. Which provides your rights to access and correct your personal information.

Signature of claimant

Signature of the policyholder if the insured is less than 16 years of age in Ontario or 14 years of age in Québec

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