HUMANIA ASSURANCE MD®

Authorizations to Release Information

Authorizations

Policy: ______________________

I authorize all medical professionals, all public or private health or social services agencies, organizations, or institutions, all insurance companies, the Medical Information Bureau, financial institutions, third party personal information agencies, investigation and security agencies, credit and claim agencies, crime detection and prevention agencies, financial intermediaries, my employer or ex-employer or any other person I may indicate as well as all public or private organizations or institutions or person that has any records or knowledge on me, my health or my insurability, to release full particulars including all prior medical history to Humania Assurance Inc., its reinsurers, other insurers and its agents, for the purpose of underwriting my application for life, critical illness or health insurance and for the adjudication and processing of claims. In the event of death, the Policyowner, contingent Policyowner, beneficiary, heir or the liquidator of the estate is expressly authorized to release to Humania Assurance all the information and authorizations required for the adjudication and processing of claims. This authorization is valid for the purposes of the present contract, its amendment, extension, reinstatement or any claim during the contestability period. A photocopy of this signed consent shall be as valid as the original.

First name:

Last name:

Date of Birth: Year / Month / Day

Date: Year / Month / Day

Signature of Person to be Insured ______________________

(children 14 and over must also sign)

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Humania Assurance Inc., 1555 Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6

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