HUMANIA ASSURANCE MD®

Authorization in the event of death

I _____ in quality of _____ authorize any health care professional, hospital, clinic, pharmacist, provincial health insurance plan, rehabilitation agency, insurer, employer or any other person or organization in possession of information concerning the deceased to release to Humania Assurance all medical, financial or other information deemed relevant in the assessment of the claim.

I authorize Humania Assurance, its agents and service providers to conduct all necessary investigations required in order to verify the validity of the claim. I accept that Humania Assurance will use the information provided for this claim and any prior claims under the same plan for the management of the claim and for production or statistical reports.

This authorization is valid for the complete duration of the present claim. A photocopy of this authorization is a valid as the original.

_____
Name of the deceased (please print)

_____
Liquidator / beneficiary (please print)

_____
Policy no.

_____
Signature

_____
Date (YYYY/MM/DD)

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

4300-018 - 04/2022

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