HUMANIA ASSURANCE MD®

Authorization

I authorize any health care professional, its agents and service providers hospital, clinic, pharmacist, provincial health insurance plan, rehabilitation agency, insurer, employer or any other person or organization in possession of information concerning myself to release to Humania Assurance all medical, financial or other information deemed relevant in the assessment of my claim.

I authorize Humania Assurance, its agents and service providers to conduct all necessary investigations required in order to verify the validity of my 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 my 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 (please print) _____ Signature _____

Policy no. _____ Date (YYYY/MM/DD) _____

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Humania Assurance Inc., 1555 Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6 4300-013 - Rev. 02/2022

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