AUTHORIZATION TO RELEASE INFORMATION

I authorize Combined Insurance, any healthcare provider, any insurance or reinsurance company, administrators of government benefits or other public or private benefits programs, any employer or former employer, or any person having knowledge of me or my health, other organizations or service providers working with Combined Insurance, located within or outside Canada, to exchange personal information, specifically to provide Combined Insurance with information, when relevant for the purposes of investigating, assessing and administering my claim(s).

This authorization shall remain valid for the duration of my claim(s) for benefits or until otherwise revoked by me in writing.

I further extend this authorization to the executor of my estate or a beneficiary to a claim(s) under the applicable insurance policy(ies) in the case of my death.

A photocopy of this authorization has the same value as the original.

Date: ______________________________

______________________________ ______________________________
Signature of Claimant **Signature of witness**

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