AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

ATTENTION OF MEDICAL DIRECTOR

I hereby authorize the Insurer to disclose to the physician mentioned below the reasons for the decision regarding my insurance application.

Name of physician: _____

Address : _____

Postal code : _____

Fax N^{o} : _____

APPLICATION FOR INSURANCE ON THE LIFE OF:

Name : _____

Address : _____

Postal code : _____

Date of birth : _____ File number: _____

Client number : _____

Signature of proposed insured or his or her legal guardian's signature, if the proposed insured is under age 18 in Quebec or under age 16 outside Quebec	Date	Signature of witness