



<input style="width: 95%; height: 20px;" type="text"/> Policyholder/insured's last name	<input style="width: 95%; height: 20px;" type="text"/> Policyholder/insured's first name
Date of birth: <input style="width: 150px; height: 20px;" type="text"/> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Year</span> <span>Month</span> <span>Day</span> </div>	<input style="width: 95%; height: 20px;" type="text"/> Application or Contract No.

1. I hereby authorize any person, organization or public or parapublic institution holding personal information about me, including healthcare professionals, medical establishments, the MIB, Inc., financial institutions, insurance and reinsurance companies, personal information agents, investigation or consumer reporting agencies, my employer or my previous employers to disclose this information to the Insurer or to its reinsurers for the purposes of determining my insurability, managing my file and considering my claims. I further authorize the Insurer and its reinsurers to disclose the personal information they hold to such individuals or organizations, including the MIB, Inc., for such purposes.
2. For these same purposes, I authorize the Insurer and its reinsurers to request an investigation report relating to me and to make a brief report to MIB, Inc. providing personal information about my health.
3. In case of death, I expressly authorize the beneficiary, the heirs or the liquidator of my estate to provide the Insurer or its assigns, when required, with any information or authorizations needed to process my file.
4. A photocopy of this authorization shall be considered as valid as the original.

Signed at \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.

  
 \_\_\_\_\_  
 Policyholder/insured's signature

  
 \_\_\_\_\_  
 Advisor's signature