La Capitale

AUTHORIZATION

Insured's last name

Insured's first name

Date of birth: Year Month Day

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. A photocopy of this Authorization is considered as valid as the original.

Signed at _____ on this _____ day of _____ 20_____.

CLAIMANT'S SIGNATURE

X _____

Claimant's signature