# MEDICAL AUTHORIZATION

Proposed insured's last name

Proposed insured's first name

Date of Birth : Year Month Day

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. This authorization shall also be valid for the collection, use and communication of personal information regarding my minor children insofar as they are concerned by my application.

4. A photocopy of this authorization shall be considered as valid as the original.

Signed at _____ on this _____ day of _____ 20_____

**PROPOSED INSURED'S SIGNATURE**

Proposed insured's signature (authorized to sign if age 14 or over in Quebec and if age 16 or over outside Quebec)

Signature of a parent or legal guardian if proposed insured is a minor

Please print the parent's or legal guardian's name

**ADVISOR'S SIGNATURE**

Advisor's signature

**La Capitale Civil Service Insurer Inc. (the Insurer)**
**La Capitale Financial Security Insurance Company (the Insurer)**
625 Jacques-Parizeau St, P.O. Box 16040, Quebec QC G1K 7X8