UV INSURANCE

INDIVIDUAL INSURANCE
Authorization form

Contract n° _____ Application n° _____

First Name insured _____ Last Name _____

AUTHORIZATION — We, the undersigned, Hereby

1. Authorize any doctor, health professional or institution according to the health and social services legislation, insurance companies, MIB Inc. or any other agency, institution or person in possession of information about us or our health to transmit it to **UV Insurance** and its reinsurers;
2. Consent that a confidential report, including personal information in relation to our solvency, be requested regarding our request for insurance and we authorize that **UV Insurance** makes a brief report of our personal health information to the MIB Inc.;
3. Attest that this authorization remains valid as long as it is not revoked and after our deaths, we consent it to be given, as the case may be, by our heirs, executors or beneficiaries to the contract, thereby renouncing in advance to the benefits of any legal disposition concerning professional secrets and authorizing any person to transmit all information requested by **UV Insurance**;
4. Acknowledge that a photocopy of the present authorization shall be as valid as the original.

Signed in _____ Y Y Y Y M M D D

X _____ **X** _____

Signature of proposed insured (if 14 years or older) | Signature of owner (if legal entity, authorized signatory)

X _____ **X** _____

Signature of advisor | Signature of father, mother or guardian (if proposed insured is a minor)

EN-1038A (2020-10)

P.O. Box 696, Drummondville (Quebec) J2B 6W9 ■ Phone: 819 478-1315 ■ Toll free: 1 800 567-0988 ■ Fax: 819 474-1990

UV INSURANCE

INDIVIDUAL INSURANCE
Authorization form

Contract n° _____ Application n° _____

First Name insured _____ Last Name _____

AUTHORIZATION — We, the undersigned, Hereby

1. Authorize any doctor, health professional or institution according to the health and social services legislation, insurance companies, MIB Inc. or any other agency, institution or person in possession of information about us or our health to transmit it to **UV Insurance** and its reinsurers;
2. Consent that a confidential report, including personal information in relation to our solvency, be requested regarding our request for insurance and we authorize that **UV Insurance** makes a brief report of our personal health information to the MIB Inc.;
3. Attest that this authorization remains valid as long as it is not revoked and after our deaths, we consent it to be given, as the case may be, by our heirs, executors or beneficiaries to the contract, thereby renouncing in advance to the benefits of any legal disposition concerning professional secrets and authorizing any person to transmit all information requested by **UV Insurance**;
4. Acknowledge that a photocopy of the present authorization shall be as valid as the original.

Signed in _____ Y Y Y Y M M D D

X _____ **X** _____

Signature of proposed insured (if 14 years or older) | Signature of owner (if legal entity, authorized signatory)

X _____ **X** _____

Signature of advisor | Signature of father, mother or guardian (if proposed insured is a minor)

EN-1038A (2020-10)

P.O. Box 696, Drummondville (Quebec) J2B 6W9 ■ Phone: 819 478-1315 ■ Toll free: 1 800 567-0988 ■ Fax: 819 474-1990

UV Insurance is a business name and trademark of The Union Life Mutual Assurance Company.