Please complete and sign three (3) copies.

A photocopy of this authorization will have the same value as the original.

Policy Number

Authorization to disclose information concerning an insured person who is deceased.

For the purpose of assessing my claim, I hereby authorize any health care professional, doctor, hospital, clinic, public or private organization, C.S.S.T., S.A.A.Q., R.R.Q., R.A.M.Q., Office of human Resources of Canada, insurance or reinsurance company or institution that holds information on the deceased person, in particular information on this person's state of health, medical history, treatments received, or any other information concerning this claim to provide this information to **SSQ Insurance Company Inc.**

I also authorize **SSQ Insurance Company Inc.** to exchange this information with other insurance or reinsurance companies or service providers for the analysis of this claim.

Name of the deceased person (in capital letters)

X

Liquidator's or beneficiary's signature

Y Y Y Y M M D D

Date

FIND0170A (2015-08)

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