beneva

Supplement to the application
Authorization

Beneva Inc.
1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

POLICY NUMBER		APPLICATION N°

AUTHORIZATIONS

1. I authorize all healthcare professionals and service providers, hospitals and public or private health or social services facilities, all insurers or reinsurers, the MIB, LLC, credit bureaus as well as all other individuals or corporations holding personal information related to their health, medical history or lifestyle habits, as required for the purposes indicated in the protection of personal information notice, to provide said information to Beneva Inc. or its reinsurers. This authorization is valid for the specific period required to process the application. A photocopy or digital version of this authorization is as valid as the original.
2. I authorize Beneva Inc. and its reinsurers to gather, use and provide, for the purposes indicated in the protection of personal information notice, to all healthcare professionals and service providers, hospitals and public or private health or social services facilities, all insurers or reinsurers, the MIB, LLC, credit bureaus as well as all other individuals or corporations holding personal information related to their health, medical history and lifestyle habits. This authorization is valid for the specific period required to process the request. A photocopy or digital version of this authorization is as valid as the original.
3. I authorize Beneva Inc. and its reinsurers to gather personal information from a credit bureau for the purposes of pricing, underwriting, assessment, research and development, statistical model creation and application, regulatory and contractual compliance as well as the prevention and detection of fraud, errors and misrepresentation. This authorization is valid for the specific period required to process the request.
4. I authorize, in the event of death, the beneficiary, the heir or the estate liquidator to provide Beneva Inc. and its reinsurers, when required, with all the information and consents required to obtain the necessary proof and process the death benefit claim.

I acknowledge having read the 4 authorizations above-mentioned and agree to them.

	X	
Name of insured (please print)	Signature of insured	Date (Y Y Y Y M M D D)
If a minor insured: Name of the mother, father or legal guardian (please print)	**X** If a minor insured: Signature of the mother, father or legal guardian (indicate relationship to the insured)	Date (Y Y Y Y M M D D)

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PLEASE ATTACH THIS FORM TO THE APPLICATION.