Please complete and sign three (3) copies.
A photocopy of this authorization will have the same value as the original.

Policy Number

Consent to collect, use and disclose personal information to third parties

I hereby authorize any health care professional, doctor, hospital, clinic, public or private organization, CNESST, 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 my state of health, my medical history, treatments I have received, or any other information concerning my claim, to provide this information to Beneva Inc.

I also authorize Beneva Inc. to use this information in processing my claim and to disclose it to the above-mentioned third parties and its reinsurers.

Name of insured (in capital letters)

Address

X

Signature

Y Y Y Y M M D D

Date

FIND0169A (2023-09)

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