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 and disclose personal information concerning a deceased person to third parties.

For the purpose of assessing my claim, 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 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 Beneva Inc.

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

Name of the deceased person (in capital letters)

X

Liquidator's/executor's or beneficiary's signature

Y Y Y Y M M D D
Date

FIND0170A (2023-09)

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