ONTARIO BLUE CROSS™

Authorization

PERSONAL INFORMATION

Insured's name: _____

Policy No.: _____ Date of birth: _____

In order to assess and evaluate my eligibility to any insurance products or benifits, I hereby authorize any licensed physician, health professional, hospital or medical institution, insurance company, the Medical Information Bureau or any other organization, institution, broker, agent, representative or any other person that previously possessed or currently has any personal, medical information or records, to give such information or records to Canassurance Hospital Service Association and/or Canassurance Insurance Company (hereafter the Association), its reinsurer, or any other institution that specializes in rehabilitation, if such a program is initiated.

In addition, I hereby authorize the Association to communicate or transmit any personal, medical information or records detained to the persons or organizations previously mentioned.

Insured's signature: _____ Date: _____

01ONT0254A (05-07)

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