NATIONAL BANK INSURANCE

AUTHORIZATION FOR DISCLOSURE OF INFORMATION
CONCERNING A DECEASED INSURED PERSON

Reference number
(for office use only) : _____

Insured : _____

Date of birth : _____

Address : _____

_____

Health insurance number : _____

MANDATORY *(The claim processing may be delayed if the information above is missing.)*

I, the undersigned, _____ ,
(Your name in capital letters)

authorize the **Medicare / Assurance-maladie (New Brunswick)** to disclose to:

National Bank Life Insurance Company
1100, Robert-Bourassa Blvd., 5th floor
Montreal (Quebec) H3B 2G7

The names of the health professionals who rendered to the above-mentioned insured services paid for by Medicare (including a list of the drugs bought), the amounts Medicare paid them for the services and the dates on which the services were rendered for the period:

From_____**to date.**
(for office use only)

Justification under the Personal Health Information Protection Act:

The information that I request be disclosed to the National Bank Life Insurance Company is needed for the defense of my interests or for the exercise of my rights or duties as:

- ☐ Heir
- ☐ Administrator of the estate
- ☐ Successor
- ☐ Beneficiary of life Insurance

I declare that I am aware of the purpose for which this information will be used by the National Bank Life Insurance Company, and therefore give my informed consent to its disclosure.

This autorisation is valid for 12 months.

_____ _____
Signature (*No reprography is accepted*) Date

_____
Signature of Witness (*No reprography is permitted*)

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