NATIONAL BANK INSURANCE

AUTHORIZATION FOR DISCLOSURE OF INFORMATION
PERSONAL RECORD

Reference number
(for office use only) **:** _____

Insured **:** _____

Date of birth **:** _____

Address **:** _____

_____

Health insurance number **:** _____

MANDATORY *(The processing of the claim 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 me 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:

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

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