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

For the purpose of assessing my claim, I authorize any health care professional, doctor, hospital, clinic, public or private organization, C.S.S.T., 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 **SSQ Insurance Company Inc.**

I also authorize **SSQ Insurance Company Inc.** to exchange this information with other insurance or reinsurance companies or service providers.

Name of insured (in capital letters)

Address

X

Signature

Y Y Y Y M M D D

Date

FIND0169A (2015-08)

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