500-5000 Yonge Street
Toronto, ON M2N 7J8
Telephone: 416-883-5000

Medical Authorization

PLEASE PRINT

Proposed Insured's Name: _____

Policy No.: _____

Authorization

For the purposes of risk assessment, investigation and loss analysis, I, the Proposed Insured, hereby authorize and direct any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau or any other organization, institution, association or person that/whosoever now has or may in future have any records or knowledge concerning me or my health to give *ivari*, its authorized representatives and its reinsurers any such information upon the request of *ivari*.

I further authorize a representative of *ivari* to perform such tests, examinations, x-rays, electrocardiograms, blood or urine tests as may be required by *ivari*. I understand and agree that such tests may include, but are not limited to, tests for kidney disease, liver disease, bone disease, risk factors for heart disease, AIDS or evidence of exposure to the HIV virus, and the presence of medications, drugs, nicotine or their metabolites. *ivari* may release the results of these tests and examinations to my personal physician(s).

PLEASE PRINT

Medical Advisor's Name: _____

Address: _____

A photocopy of this Authorization shall be as valid as the original.

Signed at: _____ on D D / M M / Y Y Y Y

Sign Here _____

Proposed Insured *(if Proposed Insured is a minor the signature of a Parent or Legal Guardian is required)*

Sign Here _____

Witness to Signature