

Group Life and Disability Claims Department**Quebec**
PO Box 790, Station B
Montreal, QC H3B 3K6**All Other Provinces**
522 University Avenue, Suite 400
Toronto, ON M5G 1Y7**GENERAL INFORMATION**

Claim no.: _____ Policy no.: _____ Certificate no.: _____

Insured's last name: _____ Insured's first name: _____

I HEREBY AUTHORIZE any healthcare provider or professional, medical organization, MIB Inc., any insurance or reinsurance company, investigation and credit reporting agency, workers' compensation board, the policyholder, my employer, as well as any other person, private or public organization or institution, to disclose and exchange any personal or health information, records (including physicians' notes) or knowledge concerning myself, with Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group"), its employees, reinsurers or any agency acting on behalf of iA Financial Group, as required for the purpose of assessing my disability claim.

LIMITATION PERIOD NOTICE

In accordance with certain legislation, we are required to advise you that your claim under your group policy is governed by a limitation period set out in the Insurance Act or other applicable legislation in your province (e.g., Limitations Act, 2002 (Ontario), Civil Code of Québec). This means you cannot sue after a certain period of time has passed. You must obtain your own independent advice regarding this limitation period.

Insured's signature **X** _____ Date _____**Group Life and Disability Claims Department****Quebec**
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