Third-Party Authorization Consent

For Critical Illness Claims

I hereby authorize the insurer and its representatives to release or discuss information regarding my Critical Illness claim with the individual/organization specified below.

Policyholder/Claimant Information

Full Name

Date of Birth YYYY-MM-DD

Policy Number

Authorized Third Party Information

Full Name / Organization

Relationship to Claimant

Contact Information

Details of Authorization

Scope of Information to be Shared / Special Instructions

Effective Date YYYY-MM-DD

Expiry Date (if applicable) YYYY-MM-DD

I understand that this authorization may be withdrawn by me at any time by providing written notice to the insurer, except to the extent that action has already been taken in reliance on it. A photocopy of this authorization shall be as valid as the original.

_____

Signature of Claimant/Policyholder

Date: _____

_____

Signature of Witness

Date: _____