Please complete and sign three (3) copies.

Signature

A photocopy of this authorization will have the same value as the original.

Policy Number	

Consent to collect, use and disclose personal information to third parties

I hereby authorize any health care professional, doctor, hospital, clinic, public or private organization, CNESST, 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 Beneva Inc.

or any other information concerning my claim, to pr	rovide this information to Beneva Inc.	
I also authorize Beneva Inc. to use this information	in processing my claim and to disclose it to the above-mentioned third partie	s and its reinsurers.
Name of insured (in capital letters)		
Address		
X	Y , Y , Y , M , M , D , D	
Signature	Date	
		FIND0169A (2023-09)
Please complete and sign three (3) copies		Delian Nimekan
A photocopy of this authorizati	on will have the same value as the original.	Policy Number
Consent to collect, use and dis	close personal information to third parties	
	octor, hospital, clinic, public or private organization, CNESST, S.A.A.Q., R.R.Company or institution that holds information on my state of health, my medical rovide this information to Beneva Inc.	
I also authorize Beneva Inc. to use this information	in processing my claim and to disclose it to the above-mentioned third partie	s and its reinsurers.
Name of insured (in capital letters)		
Address		
X	Y , Y , Y , M , M , D , D	
Signature	Date	
		FIND0169A (2023-09)
Diago complete and sign three	2) conice	
Please complete and sign three (3) copies A photocopy of this authorization will have the same value as the original.		Policy Number
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Consent to collect, use and dis	sclose personal information to third parties	
	ector, hospital, clinic, public or private organization, CNESST, S.A.A.Q., R.R.Company or institution that holds information on my state of health, my medical rovide this information to Beneva Inc.	
I also authorize Beneva Inc. to use this information	in processing my claim and to disclose it to the above-mentioned third partie	s and its reinsurers.
Name of insured (in capital letters)		
Address		