

E. Certification and Authorization

The insurer, its agents, administrators and/or their designated representatives (collectively "Group Medical Services") are obliged to collect and retain certain personal and/or health information about you in connection with your insurance coverage. They use and disclose that information only for the purposes of administering your policy/policies of insurance, providing customer service and assessing and paying claims.

- I/We authorize any licensed physician, medical practitioner, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, provincial health insurance plan and employer(s) to provide Group Medical Services, and their respective representatives employed to assist in the administration of this claim, any information, including personal information, data, or records that are in their possession/knowledge, regarding my medical history and treatment.
- I/We direct and authorize my government health insurance plan (GHIP) to make payment in respect of my claim for out-of-country health services to Group Medical Services directly and I hereby release GHIP, upon payment to Group Medical Services, from any further claim or cause of action in connection herewith.
- I/We hereby consent and authorize GHIP to directly or indirectly collect information contained in the claim and source documents pursuant to the Freedom of Information and Protection of Privacy Act and the Health Information Protection Act.
- I/We authorize Group Medical Services to coordinate the payment of benefits with any other insurance carriers which may also have a liability for this claim.
- I/We hereby authorize irrevocably Group Medical Services to make any payments, receive payments and settle with any carriers on my behalf.

I hereby consent to the collection, use and disclosure by the insurer, its agents and administrators of the personal and health information about me disclosed herein and in all documents or information provided in connection with my policy/policies of insurance for the purposes cited above.

If the undersigned is signing on behalf of any person(s), the undersigned represents to having the authority to sign on behalf of such person(s) and confirms that each of the above declaration and authorizations are also provided on behalf of such person(s) and confirms that each of the above declaration and authorizations are also provided on behalf of such person(s).

A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from date signed.

X

(Print Full Name)

DD / MM / YYYY

Signature of Claimant

Claimant

Date

If claimant is dependant, print full name of parent or guardian, or if claimant is deceased, print full name of executor.