P.O. Box 4241, Station A
Toronto, ON M5W 5R3

Medical Authorization

Policy Number:

Name of Insured: _____ Date of birth: _____ (DD/MM/YYYY)

Authorization

For the purposes of evaluating my insurance application, servicing my policy, investigation and claim analysis, I, authorize and direct any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the MIB, LLC or any other organization, institution, association or person that now has or may in future have any records or knowledge concerning me or my health to disclose to ivari, its authorized representatives and its reinsurers, upon the request of ivari, any such information that is deemed to be material by 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).

Medical Advisor's Name: _____

Address: _____

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

Signed at: _____ on _____ (DD/MM/YYYY)

_____

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

_____

Witness to Signature

SAVE PRINT CLEAR