



**AUTHORIZATION TO  
OBTAIN INFORMATION  
(DECEASED)**

Chubb Life Insurance Company of Canada  
199 Bay Street - Suite 2500  
P.O. Box 139, Commerce Court Postal Station  
Toronto, Ontario M5L 1E2  
O +1.416.594.2627 or +1.877.772.7797  
claims.A\_H@chubb.com

Name of Insured: \_\_\_\_\_

I authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, possessing records or knowledge concerning the late

\_\_\_\_\_

to give to Chubb Insurance or Chubb Life Insurance Company of Canada all such information. I consider such information to be essential to Chubb Insurance or Chubb Life Insurance Company of Canada in complying with its obligations as a provider of benefits.

I am granting this authorization and direction in my capacity as

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and concerning my interests or rights in such capacity. Unless, at any earlier time, I withdraw this authorization (notice of which will be provided by Chubb Insurance or Chubb Life Insurance Company of Canada, as applicable; until such notice is received, the authorization shall be deemed to remain in effect), this authorization will remain in effect for so long as Chubb Insurance or Chubb Life Insurance Company of Canada requires and, in any event, for not less than twelve (12) months and for not greater than twenty-four (24) months from the effective date of this authorization, as indicated below. A reproduction of this authorization shall be as valid as the original.

Name (Please Print) \_\_\_\_\_ Signature \_\_\_\_\_

Dated at \_\_\_\_\_ of \_\_\_\_\_  
City/Town Region/Municipality

In the Province of \_\_\_\_\_ on this \_\_\_\_\_ day

of \_\_\_\_\_  
Month and Year

Signature of Parent/Guardian if Child is a Minor \_\_\_\_\_