

CLAIM FORM

Consent Form for Disclosure of Treatment History



A member of the Pacific Cross Group of Companies

At:

Date:

SUBJECT: Consent to Disclose Treatment History

Dear: Hospital Director

[Redacted]

(Name of Hospital / Clinic)

I, Mr / Mrs / Ms. permit doctors, hospitals / clinics to disclose all of my detailed medical records to Pacific Cross Health Insurance PCL to process Compensation consideration, Underwriting consideration, including the renewal of my insurance policy Including disclosure of information to regulatory agencies or related departments until this authority is revoked.

Please be informed and proceed accordingly

Sincerely Yours

Signed

Name ()

A copy of this consent form shall be considered effective and complete as the original

NOTE: attached is a copy of my ID Card / Passport duty certified as a true copy.