500-5000 Yonge Street
Toronto, ON M2N 7J8

Authorization for eApplication

Policy No.: _____

Name of Proposed Insured 1: _____

Name of Proposed Insured 2: _____

Name of Owner 1: _____

Name of Owner 2: _____

Name of Payor, if other than Proposed Insured(s) or Owner(s): _____

Name of Independent Insurance Advisor: _____

Authorization

As the electronic application will not be fully executed and signed in person, you the Proposed Insured(s), Owner(s) and Payor, if applicable, each authorize your independent insurance advisor noted above to complete and sign the electronic application on your behalf including any supplementary health information forms and temporary insurance agreement if applicable (in accordance with *ivari's* procedures and its accepted practices), with the same effect as if you had completed and signed the insurance application in person with your independent insurance advisor. You will be asked to provide information just as you would if completing the insurance application in person. You further authorize your independent insurance advisor to insert the policy number into this form should it not be available at the time of signing the authorization form.

PERSONAL INFORMATION AUTHORIZATION

For the purposes of risk assessment, investigation and claims, I/we, the Proposed Insured(s), hereby authorize and direct any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the MIB, Inc. or any other organization, institution, association or person identified in the Notice of Disclosures that now has or may in future have any records or knowledge concerning me/us or my/our 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* for the purposes identified in the Notice of Disclosures. I/We authorize *ivari*, or its reinsurers, to make a brief report of my/our personal health information to MIB, Inc.

I/We further authorize a representative of *ivari* to perform such tests, examinations, x-rays, electrocardiograms and blood or urine tests as may be required by *ivari*. I/We 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).

A photocopy of this Authorization shall be as valid as the original. You authorize *ivari* and your independent insurance advisor to act on a faxed or electronically sent copy of this signed form which is to be considered as the original from which further copies may be made that will be equally valid. Your authorizations will take effect on the date you sign this form and will remain in effect until the purposes for which they were provided have expired.

Signed at (city) _____ in the province of _____ on _____
(DD/MM/YYYY)

Sign here **PRINT AND SIGN**
Signature of **PROPOSED INSURED 1**
If Proposed Insured is a minor the signature of a parent or legal guardian is required

Sign here **PRINT AND SIGN**
Signature of **PROPOSED INSURED 2**
If Proposed Insured is a minor the signature of a parent or legal guardian is required

Sign here **PRINT AND SIGN**
Signature of **OWNER 1,** if not a Proposed Insured

Sign here **PRINT AND SIGN**
Signature of **OWNER 2,** if not a Proposed Insured

Sign here **PRINT AND SIGN**
Signature of your Independent Insurance Advisor

Sign here **PRINT AND SIGN**
Signature of Payor, if not Proposed Insured(s) or Owner(s)