



**AUTHORIZATION TO  
OBTAIN INFORMATION  
(CLAIMANT)**

Please return to: J&D Benefits Inc.  
228-8901 Woodbine Avenue  
Markham, ON L3R 9Y4  
Telephone: 905-477-7088 1-800-218-7018

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

I am granting this authorization and direction in my capacity as a claimant 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, 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 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 consent 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 \_\_\_\_\_