Authorization for the collection and release of personal information to third parties

Desjardins Insurance
LIFE • HEALTH • RETIREMENT

Please complete and mail this form to:

Dispute Resolution Officer
Desjardins Financial Security
200, rue des Commandeurs
Lévis (Québec) G6V 6R2

I authorize the Dispute Resolution Officer of Desjardins Financial Security Life Assurance Company and its representatives to disclose all personal or confidential information that they have about me to _____

_____

_____

(*Please print the name, address and phone number of the person representing you.*)

pursuant to the review of my complaint filed on _____ (*date*) concerning

_____

_____

_____

_____

(*Briefly explain your complaint.*)

It is understood that I also authorize _____ (*name of the person representing you*) to disclose all personal or confidential information concerning me to the Dispute Resolution Officer and his representatives as part of the review of this complaint.

This authorization is valid from the day it is signed and until the Dispute Resolution Officer makes the final decision regarding this complaint.

A photocopy of this authorization is as valid as the original.

Signed at _____ (*city*), on _____ / _____ / _____ (*day*) (*month*) (*year*)

Name of the insured: _____ (*Please print.*) Signature of the insured: _____

Address: _____

_____

_____

Date of birth: _____ / _____ / _____ (*day*) (*month*) (*year*)

Telephone: _____

Witness: _____ (*Please print.*) _____ (*signature*)

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Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.