**AXA Assurances Inc.**

# Consent to collect, use and disclose personal information

## (Accident and Sickness Claims)

I authorize AXA Assurances Inc. and its authorized representatives to collect, use, and disclose personal information about me and, where applicable, my dependent children as permitted by law from and to the following persons and organizations:

- any licensed medical practitioner or licensed health professional, hospital, clinic or medically related facility;
- any other insurance company or financial institution, including any reinsurance company;
- any other person or organization with information relevant to my claim; and
- any person or organization that provides information services or insurance services to, or that acts as insurance intermediary for AXA Assurances Inc.;

for the following purposes:

- establishing and maintaining communications with me;
- underwriting group risks on a prudent basis;
- investigating and settling claims;
- detecting and preventing fraud;
- offering and providing products and services to meet my needs;
- compiling insurance statistics; and
- complying with the law.

The personal information collected by AXA Assurances Inc. will be entered into a file whose subject is accident and sickness insurance. The file will be kept at AXA Assurances Inc. offices. Within AXA Assurances Inc., this file will only be accessed by those employees who require access in order to fulfill the purposes listed above. I understand that I may access my personal information contained in this file and correct such information if necessary by directing a written request to:

Privacy Officer
AXA Assurances Inc.
2020, University Street
Suite 700
Montréal, Québec H3A 2A5

This consent shall be valid for the length of time necessary for AXA Assurances Inc. to achieve the purposes listed above. I may withdraw this consent at any time by giving AXA Assurances Inc. written notice of withdrawal. I understand that withdrawal of my consent might result in AXA Assurances Inc. being unable to provide me with a product or service.

A copy of this consent shall be considered as effective and valid as the original.

Date of the occurrence D M Y Cause (accident, illness, etc.): .....

Signature of Insured | Print Name | Policy Number

Date D M Y Telephone ( )

Address .....
Street & Number | City | Province | Postal Code

**Where the claim is for the Accidental Death of the Insured Person, this consent must be signed by their authorized representative, and shall apply to both the Insured Person and the authorized representative:**

Signature of Authorized Representative | Print Name | D M Y Date

Relationship to the Insured: .....

The completed authorization can be returned to AXA Assurances Inc. at any of the following addresses:

**1075 Bay Street, Toronto, Ontario M5S 2W5**
**2020 University Street, Suite 700, Montreal, Quebec H3A 2A5**
**645 – 7th Avenue S.W., Suite 1400, Calgary, Alberta T2P 4G8**