Cigna Life Insurance Company of Canada
100 Consilium Place, Suite 301
Scarborough, Ontario, Canada M1H 3E3

Certain Services Provided by Cigna Global Health Benefits
Mailing Address: P.O. Box 15050
Wilmington, DE 19850

Consent to Disclose Personal Health Information

CLEAR FORM

Customer Name: _____ **Subscriber Number:** _____

Date of Birth: (___ / ___ / _____) **Employer Name:** _____

I, _____ **, hereby authorize Cigna Life Insurance Company of Canada to**
(Print your name)

disclose my personal health information consisting of: _____

_____
(Describe the personal health information to be disclosed)

Or the personal health information of: _____
(Name of person for whom you are the substitute decision - maker)*

consisting of: _____
(Describe the personal health information to be disclosed)

to: _____
(Print name and address of person requiring the information)

The purpose for disclosing this personal health information to the person noted above is:

_____
(If left blank, this consent form will be returned to you for completion)

I also understand that I can refuse to sign this consent form. This consent will remain in effect for a period of not less than twelve and not more than twenty-four months, however I understand that I may revoke this authorization by sending a written request to the address as indicated above. I agree that a photocopy of this authorization shall be as valid as the original.

My Name: _____ Address: _____

Home Tel.: _____ Work Tel.: _____

Signature: _____ Date: _____

Witness Name: _____ Address: _____

Home Tel.: _____ Work Tel.: _____

Signature: _____ Date: _____

***Please note: A substitute decision-maker is a person authorized under the appropriate Provincial Health Act to consent, on behalf of an individual, to disclose personal health information about the individual.**

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