

**AUTHORIZATION AND RELEASE**

*Please complete this Authorization and Release form and return this to Canada Life as soon as possible to ensure prompt assessment of your claim. This will allow Canada Life to co-ordinate benefits directly with your Provincial health plan.*

I, \_\_\_\_\_ (patient) irrevocably direct and authorize Ontario Ministry of Health and Long-Term Care (O.H.I.P.) to make payment in respect of my claim for out-of-country health services to The Canada Life Assurance Company directly, and I hereby release O.H.I.P., upon payment to The Canada Life Assurance Company from any further claim or cause of action in connection therewith.

I hereby consent and authorize O.H.I.P. to directly or indirectly collect information contained in the claim source documents pursuant to Section 39(1) of the *Freedom of Information and Protection of Privacy Act* and Section c. H.6 of the *Health Insurance Act*, R.S.O. 1990.

I consent to the disclosure of O.H.I.P. to The Canada Life Assurance Company of such personal information as may be necessarily required for the processing of my claim for out-of-country health services, including the details of any duplicate payment previously made directly to me.

Please provide all of the information requested below, including your Canada Life Plan and ID Number. This form will be returned to the claimant if not fully completed.

Date: \_\_\_\_\_ Year \_\_\_\_\_

\_\_\_\_\_  
Signature of or on Behalf of Insured

\_\_\_\_\_  
Signature Printed

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Patient's Ontario Health Insurance Number

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Patient's Version Code

\_\_\_\_\_  
Patient's Birthdate

*Please attach a photocopy of your current O.H.I.P. Health Card if possible. This will ensure accurate and timely coordination of benefits with your provincial health plan.*

\_\_\_\_\_  
Canada Life I.D./Cert. Number

\_\_\_\_\_  
Canada Life Plan Number/Employer

**RETURN TO: GROUP OUT-OF-COUNTRY CLAIMS**