

**AUTHORIZATION TO DISCLOSE INFORMATION TO MY ADVISOR**

You may not make any changes to the content of this authorization.

In this form, you and your refer to the Proposed Life Insured. We, us, our and the company refer to BMO Life Assurance Company.

Application No.	Legal Name (first, middle initial, last) of Proposed Life Insured	Date of Birth (dd/mm/yyyy)
Advisor's full name (first, middle initial, last)		Advisor's Code number
Advisors designated affiliate (if applicable)		

**Purpose of this authorization**

If you sign this form, you give us permission to discuss your personal (including medical) information with your advisor or designated affiliate who may use it to discuss insurance options with you.

***We do not need this authorization to review and make a decision about your application.***

**The Authorization you provide when you sign this form**

By signing below, you authorize the company to discuss information about you, which was collected on the application number set out above.

The information about you that we may discuss with your advisor or designated affiliate can include:

1. Medical testing and laboratory results\*;
2. Confidential personal information about illness, including mental illness, other medical conditions, use of medications, drug or alcohol use and rehabilitation;
3. Other information about your health discovered as we assess your application but that you may not know about when you apply;
4. Employment history and personal finances;
5. Any record of criminal activity; and
6. Other facts about your life and how they affect our decision to insure you.

\*We reserve the right to not share all sensitive medical/financial information should we see fit. We may choose not to share information about you that we have obtained from a physician or medical facility where that information was not disclosed to us as part of the application process.

**Your agreement and signature**

By signing this form, you agree:

1. You have read and understood the purpose of this authorization;
2. You are authorizing us to discuss information, set out in this form, to your advisor or designated affiliate;
3. Even though you have signed this form, we have the right to withhold highly sensitive personal information from your advisor or designated affiliate;
4. You may cancel this authorization at anytime by sending us a letter in writing to the address noted above; and
5. You understand that this authorization remains valid until **30 days** after the later of the day we;
  - (a) issue a new insurance policy or amend an existing insurance policy, or
  - (b) we mail you a notice telling you that we have declined your application.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

\_\_\_\_\_  
 Signature of Proposed Life Insured or Consenting Parent or Guardian  
 (Child age 16 or older, age 18 or older in Quebec, must sign form)

\_\_\_\_\_  
 Printed name of Consenting Parent or Guardian signature that is indicated above (if applicable)

***A copy of this authorization will be as valid as the original.***