AUTHORIZATION FORM

I, undersigned,

Name of liquidator: _____,

in my capacity as liquidator of the will of the claimant

Name of claimant: _____,

hereby authorize Services Proactio Inc., as part of their function as administrator of the claims of class action No. 500-06-001109-202, to obtain a copy of any document relating to preventive confinement contained in my following medical file:

Name the hospital: _____

IN WITNESS WHEREOF, I HAVE SIGNED
IN _____, ON _____
(City) **(Date)**

_____
Signature

INFORMATION ABOUT THE CLAIMANT:

FIRST AND LAST NAME: _____

DATE OF BIRTH: _____

FATHER'S FIRST AND LAST NAME: _____

MOTHER'S FIRST AND LAST NAME: _____

HEALTH INSURANCE NUMBER: _____

SECTION TO BE COMPLETED BY THE ADMINISTRATOR ACCORDING TO THE INFORMATION PROVIDED:

Period covered: _____