AUTHORIZATION FORM

I, undersigned,	
Name of the representative:	,
in my capacity as representative, of the claim	nant
Name of the claimant:	,
hereby authorize Services Proactio Inc., as p	part of their function as administrator of the claims of
class action No. 500-06-001109-202, to ob	otain a copy of any document relating to preventive
confinement contained in my following med	lical file:
Name the hospital:	
	IN WITNESS WHEREOF, I HAVE SIGNED IN, ON
	(City) (Date)
	Signature
INFORMATION ABOUT THE CLAIMANT AC PROVIDED:	CORDING TO THE INFORMATION
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 ADM	INISTRATOR:
Period covered:	