

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: _____