



**APPLICATION FOR GROUP CRITICAL ILLNESS BENEFIT CLAIM - PAGE 2**

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f) Have you previously suffered from or received treatment for the same or a similar disease or condition? If yes, provide details and dates: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3. MEDICAL CONSULTATIONS**

a) Name and address of your personal physician: \_\_\_\_\_  
\_\_\_\_\_

b) Names, addresses and dates seen by any other physicians or specialists for this disease or condition: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c) Names and address of any hospital or other medical facility admitted to or discharged from concerning this disease or condition, to include the dates: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby give permission to any physician, medical practitioner, hospital, medical facility, insurance or reinsurance companies to release, upon presentation of the original or a photocopy of this signed and dated authorization, requested information to **Windsor Life Insurance Company** or its representative (specifically the Claims Department, Medical Director, Legal Department, or Investigative Agency) in connection with any disease, treatment, prior medical history or prescription. This authorization includes information relating to medical illness, use of drugs, and use of alcohol. I understand that such information will be used by **Windsor Life Insurance Company** for the purpose of evaluation of my claim for insurance benefits, and I wish this authorization to be effective from the date signed for the duration of the claim.

Date \_\_\_\_\_

Signature of Insured \_\_\_\_\_