CONSENT TO MEDICAL/PHYSICAL INFORMATION

NAME: **[A - INSERT PERSON'S NAME]**

I have been asked by the Ontario Pension Board to provide medical documentation in support of my application for a **Disability Pension /Disability Benefit**.

I hereby authorize and direct any physician, medical practitioner, hospital, WSIB, clinic or other medical or medically related facility, institution or person that has records or knowledge of my health as it pertains to the above application, to provide such information to Cowan Insurance Group Ltd..

I also authorize Cowan Insurance Group Ltd. to release relevant medical reports to medical professionals, medically related facilities, WSIBs and relevant insurance companies, as applicable.

I understand that Cowan Insurance Group Ltd. will provide the Ontario Pension Board with its assessment and opinion whether I am totally and permanently disabled as defined in the *Public Service Pension Plan*.

Please note that a photostatic copy of this authorization shall be considered as effective and valid as the original.

Dated this ________________ day of ________________________________, ______

Applicant's Signature: ____

[B - PUT PERSON'S NAME AND CLIENT NUMBER UNDER THE SIGNATURE LINE]

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