Authority to Release Information for Life Insurance Claims

Colonial First State

The purpose of this form is to provide authority to enable AIA Australia to appropriately assess the claim, by seeking any required information to further understand the deceased's medical history.

Section A – Authority to release information

I,

_____ (print name), of

_____ (authoriser's address),

being Executor/Trustee/Next of Kin/the Attorney under a Power of Attorney (delete not applicable) of

_____, do hereby consent to AIA Australia seeking and receiving any and all information from any Employer, other Insurer (including Workers' Compensation & CTP), Rehabilitation Provider, Government Authority (including Centrelink) and/or seeking medical information from any medical practitioner, hospital or other medical institution.

It is my intention that a photocopy or electronically transmitted image of this authority shall have the same effect as an original authorisation signed by me.

Full Name of insured

Date of Birth / /

Insured's residential address

State Postcode

Insured's postal address (if different from above)

State Postcode

Please sign and date below:

Full name of authoriser

Signature of authoriser

X

Date / /

Please note we may be in contact to request further information.

For AIA Australia use only

Policy Number K00

Plan Name