Letter of Consent

Instructions

1. **Print answers to ALL questions. If you have additional remarks, attach a separate sheet.**
2. **Sign and date the form.**
3. **Return the completed form to the Credit Union.**

Part I: Member Information

Deceased Member's Name **(last/first/middle)**	
Credit Union Name	
Doctor's Name	
Doctor's Address	
Doctor's Phone	

Part II: Authorisation for release of Medical and Employment Information

I authorise any doctor, hospital, clinic, other medical related facility, insurance or reinsuring company, or employer having information available as to history, diagnosis, treatment, and prognosis with respect to any physical or mental condition of the deceased member to release to Maiden Life Försäkrings AB. or its legal representative, any and all such information. I understand the information obtained by this Authorisation will be used to determine eligibility for benefits under this policy. Any information obtained will not be released to any person or organisation except to reinsurance companies, or other persons or organisations performing business or legal services for these companies in connection with this claim, or as may be otherwise lawfully required. I know I may request a copy of this Authorisation. I agree this Authorisation shall be valid for the duration of the claim.

Member's Next of Kin Name:			
Address:			
Signature		Date	

For Office Use Only	
Claim Number	