

## CONSENT TO MEDICAL/PHYSICAL INFORMATION

NAME: \_\_\_\_\_

I have been asked by the Ontario Pension Board to provide medical documentation in support of my application for a pension for a **dependant with a disability**.

I hereby authorize and direct any physician, medical practitioner, hospital, WCB, clinic or other medical or medically related facility, institution or person that has records or knowledge of my health/the health of the disabled child known as \_\_\_\_\_ 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, WCBs 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 have/the applicant child has a continuing mental or physical infirmity that causes financial dependence on another person.

**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: \_\_\_\_\_