AGA BENEFIT SOLUTIONS

CONSENT FORM AUTHORIZING CUSTOMER SERVICE TO DISCLOSE PERSONAL INFORMATION IN RELATION WITH YOUR GROUP INSURANCE

Complete this form if you, the Plan Member, would like another person (spouse, your Advisor, your Plan Sponsor, a relative, etc.) to call Customer Service on your behalf. By completing this form, you acknowledge that Customer Service is authorized to disclose to the caller your personal information and information about your claims and/or coverage. You also acknowledge that Customer Service is authorized to disclose to the caller personal information about your dependents under the age of 14 along with information about their claims and/or coverage. Note: The level of information disclosed to the caller will vary based on your selections below – please read this form carefully.

This consent does not apply to Members Portal access https://adherents.aga.ca/en/login or to the related technical support, nor to banking information that shall not in any case be disclosed to the authorized person.

AGA Benefit Solutions is committed to maintain the security and privacy of your information, including data collected through this form that are required to identify the authorized third party. AGA Benefit Solutions will disclose such personal information only to its employees who need to know it in the performance of their duties and, if applicable, to subcontractors, and will keep it for the limited period of time required to fulfill the objectives of AGA Benefit Solutions. To learn more about our privacy guidelines and rules, including for exercising your rights of access and correction, please contact conformite@aga.ca or go to our website www.aga.ca/en/personal-information-protection.

1. ADMINISTRATIVE INFORMATION

Last Name	First Name
Group No.	Certificate No.
Telephone No. (Daytime)	Email

2. PERSONS AUTHORIZED TO RECEIVE PERSONAL INFORMATION

Please complete this section if you want to authorize another person to access:

☐ Your personal information and/or

☐ Personal information of dependent children (under 14). Please indicate the names of dependent children concerned:

☐ Personal information of spouse

☐ Personal information of children over 14

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3. PERSONS YOU AUTHORIZE TO RECEIVE PERSONAL INFORMATION CONCERNING YOU

1st authorized person:		
Last Name	First Name	Relationship to you
2nd authorized person:		
Last Name	First Name	Relationship to you

Member	Spouse	Child under age 16	Child over age 16	Type of personal information that can be disclosed to the authorized persons I indicated (Check all boxes that apply)	
☐	☐	☐	☐	☐	Group insurance plan coverage
☐	☐	☐	☐	☐	Medical expense claims
☐	☐	☐	☐	☐	Dental expense claims
☐	☐	☐	☐	☐	Disability claims (information related to the receipt of documents, payment of benefits, insurer decision)
☐	☐	☐	☐	☐	Distinction on type of coverage/administrative information except beneficiary
☐	☐	☐	☐	☐	Other (Please specify and indicate any restriction):

Consent period: This consent is valid for a period of 1 year following the signing date of this document, unless it is revoked, whichever occurs first.

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4. AUTHORIZATION AND SIGNATURE

I hereby authorize AGA Benefit Solutions to disclose personal information concerning me and/or personal information concerning my aforementioned dependent children under 14 and over 14 and my spouse to the persons and for the purposes indicated in this form.

I agree that any photocopy or electronic version of this authorization is as valid as the original. This consent is valid until withdraw it in writing.

Member's Signature	Date (YYYY-MM-DD)
Spouse's Signature (if applicable)	Date (YYYY-MM-DD)

Please send the completed form to our **Customer Care Team** at the following email address: service.client@aga.ca.