



## CONSENT TO APPOINT PERSONAL HEALTH/INSURANCE REPRESENTATIVE

PLEASE PRINT

### SECTION A: YOUR CONSENT

The insured person must complete and sign this section

I, \_\_\_\_\_, hereby give my consent for MSH International (Canada) Ltd.  
Full name

to communicate personal, private, medical and/or claim information on my behalf, to the authorized person, named in Section B, concerning any medical and personal aspects of my insurance policy and health condition(s). I understand that this authorized person does not have any authority to act on or change any of my personal/medical information and/or insurance policy. I understand that this consent is valid for 1 year from the signed date and can be revoked at any time upon request to MSH International (Canada) Ltd.

\_\_\_\_\_  
Signature Date (MM/DD/YYYY)

### SECTION B: APPOINTED PERSONAL HEALTH/INSURANCE REPRESENTATIVE

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Full Name of Appointed Personal Health/Insurance Representative

#### CONTACT DETAILS

\_\_\_\_\_  
Mobile Number Home Number Email Address

#### MAILING ADDRESS

\_\_\_\_\_  
Street, Apt., P.O. Box City State/Province ZIP/Postal Code Country

I understand that I am authorized to communicate with MSH International (Canada) Ltd. on behalf of the person named in Section B. This communication is limited to the provisions indicated in Section A. I also understand that I do not have the authority to act on or change any personal/medical information and/or insurance policy of the named individual. I understand that this consent is valid for 1 year from the signed date and can be revoked by the person named in Section A at any time upon request to MSH International (Canada) Ltd.

\_\_\_\_\_  
Signature of Appointed Personal Health/Insurance Representative Date (MM/DD/YYYY)