



AUTHORIZATION TO RELEASE EVIDENCE

To: Medical Director
Equitable
One Westmount Road North
Waterloo, Ontario
N2J 4C7

Dear Sir/Madam:

Re: Equitable® Policy # _____ on the life of _____.

Please indicate the nature of the evidence upon which Equitable made its decision on my recent insurance application. You may send your reply to my Attending Physician:

Physician's Name: _____

Address: _____

Postal Code: _____

Phone Number: _____

Fax Number: _____

Date: _____

Signature: _____

Life Insured