To Be Completed By The Claimant

I hereby authorize any hospital, physician or other person who has attended me, or any employer, to furnish the above checked Company or its' representatives, any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatments, copies of all hospital or medical records and copies of all records of employers. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original.

Signed:______________________________ Date:____________________________