

# Third party

I, \_\_\_\_\_,  
INSURED PERSON  
give permission for \_\_\_\_\_  
THIRD PARTY  
to have access to any and all relevant claims information,  
including medical records, related to the adjudication  
of my claim # \_\_\_\_\_ with AZGA Service Canada Inc.  
POLICY NUMBER  
o/a Allianz Global Assistance.

I understand that this information will be shared between Allianz Global Assistance and the third party named above solely for the purpose of this person assisting me in understanding the claim adjudication and its results.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

DAY MONTH YEAR

\_\_\_\_\_  
SIGNATURE OF INSURED PERSON

\_\_\_\_\_  
NAME OF INSURED PERSON (PLEASE PRINT)

**Allianz Global Assistance**

Toll free: 1-800-869-6747  
Fax: 416-340-7152