MEDIC SOLUTIONS
Group insurance, evolved

EMAIL COMMUNICATION AUTHORIZATION FORM

Employer's Name

Information regarding the plan member

Last name	First name

Certificate No.

Email address

Please complete this form, sign it and return it to us so that your email address may be entered into your file.

Declaration and Consent

I authorize Medic Solutions to contact me by email.

It is my responsibility to notify Medic Solutions about any changes regarding this authorization, which I may cancel at any time by contacting Medic Solutions directly.

Any email communication may include confidential information, specifically information regarding my statements of claim.

Date (dd/mm/yy)	Signature of the Plan Member

Please email your completed form to: participant@medicsolutions.ca

RESERVED FOR MEDIC = Medic - Client No.: ____________ Medic - Certificate No.: ____________

Email-En-0919