

Reserved for Medic Solutions

Medic Client No. _____

Medic certificate No. _____

Employer's name

Information regarding the plan member

Last name

First name

Certificat No.

Email address

Please sign the form and return it to Medic Solutions in order to update 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 (mm/dd/yyyy)

Signature of the plan member

Please email your completed form to:

participant@medicsolutions.ca

Reset form