**CONSENT FOR THE RELEASE OF INFORMATION FORM**

**CLAIMANT DETAILS**

|  |  |
| --- | --- |
| Name of Claimant | {{name\_of\_claimant}} |
| NRIC / Passport No. | {{claimant\_nric}} |
| Date | {{claimant\_date}} |

**INSURED DETAILS**

|  |  |
| --- | --- |
| Name of Insured | {{name\_of\_insured}} |
| NRIC / Passport No. | {{insured\_nric}} |

I hereby authorize and give my consent to any medical practitioner, physician, surgeon, clinic, hospital, medical centre, insurance company or other organizational, institution or individual concerned ("the Information Provider(s)") that may have any records or knowledge of the employment, financial, health or medical history of the Insured and to provide such information to DearTime Berhad ("the Company”) and/or employees.

I expressly waive on behalf of myself and/or as a next-of-kin of the Insured and for his/her estate all provision of law or professional ethics forbidding the Information Provider(s) from disclosing any such information acquired on the Insured in a professional and/or client capacity and I further release the Information Provider(s) and its staff from any liability whatsoever that may arise, in supplying such information requested by the Company.

This authorization/consent is irrevocable and a copy of it will have the same effect and validity as the original.

Thank you.

This document is digitally signed by the claimant using biometric facial recognition on {{now}}. No physical signature is required.