

FAILURE TO PROVIDE ALL INFORMATION REQUESTED IN THIS FORM AND SIGNED MEDICAL AUTHORITY MAY CAUSE EXTREME DELAYS IN PROCESSING YOUR CLAIM.

Please ensure that this completed form is returned promptly to OneWorld Assist Inc. with signed medical authority.

MEDICAL AUTHORITY

All hospitals, physicians, medical care providers, insurers and other persons are hereby authorized to provide to OneWorld Assist Inc. ("OWA") all information and documentation (collectively, "medical records") in their possession regarding illnesses, injuries, medical history, consultations, medicines and treatments of the claimant named below. OWA is authorized to collect and use those medical records and to disclose them and information in them to the selling agent, and to insurers, including government health plans, that may be responsible for the claimant's medical expenses. The undersigned consents to the provision to OWA of medical records from all countries, understands that the purpose for the collection, use and disclosure of medical records is to enable OWA and insurers to determine whether and to what extent the claimant's medical expenses are covered by insurance. If medical records are required from the US, the undersigned understands that this purpose constitutes a payment operation under the privacy rules in the U.S. Health Insurance Portability and Accountability Act. The undersigned also understands that if medical records are not provided those expenses will probably not be covered by insurance. This consent takes effect on the date set out below and may be revoked at any time by the undersigned in writing. If it is revoked before OWA and insurers collect and review the medical records, the claimant's medical expenses will probably not be covered by insurance. A copy of this consent received from OWA shall be as effective and valid as the original.



Print name (and relationship if not claimant)



Signature (Claimant or authorized representative)

____ M | ____ D | ____ Y

Date