



## CONSENT FOR RELEASE OF INFORMATION

Proposal Number : \_\_\_\_\_  
Proposed Insured's name : \_\_\_\_\_  
NRIC Number of the Proposed Insured : \_\_\_\_\_  
Proposed Owner's name (if applicable) : \_\_\_\_\_  
NRIC Number of the Proposed Owner (if applicable) : \_\_\_\_\_

### CONSENT:

I, the undersigned, by signing this form, hereby authorize the below name individual, agent of AXA AFFIN Life Malaysia, for the doctor/hospital/clinic to disclose to AXA AFFIN Life Insurance Berhad, the clinic records and/health disclosure for the purpose of my insurance application. A copy of this authorization shall be as effective and valid as the original.

Signature of the the Proposed Owner : \_\_\_\_\_

Date of signing : \_\_\_\_/\_\_\_\_/\_\_\_\_

### AGENT DETAILS:

Name of the agent : \_\_\_\_\_

NRIC Number of the agent : \_\_\_\_\_

NB/CONSENTLETTER/V2.0/2020