

**APOC Voluntary Authorization for Association Representation  
and Release of Medical Information for Disability Insurance (DI) Claims**

**EMPLOYEE Portion:** Please complete the "EMPLOYEE" portion of this form and forward the completed form to the APOC National Office (28 Concourse Gate, Unit 1, Ottawa ON K2E 7T7). The APOC National Office Representative will keep this form on file for future use, only if required.

Should you require assistance with your DI claim, please contact the APOC National Office (613-727-1310), at which time this form will be signed and faxed back to Sun Life to facilitate involvement with your claim.

Under an agreement between Canada Post Corporation and the Association of Postal Officials of Canada (APOC) I am able to authorize an Association Representative to represent me.

Therefore, I authorize an APOC Association Representative to represent me in the Disability Insurance appeal process. I hereby authorize Sun Life Assurance Company of Canada ("Sun Life" or the Insurance Carrier) to release to my APOC Association Representative all information, including medical information, contained in my file with Sun Life Assurance Company of Canada.

I agree that a photocopy of this authorization or electronic version is as valid as the original and shall continue to have effect throughout the duration of my DI claim.

\_\_\_\_\_

Name of Employee

\_\_\_\_\_

Signature of Employee

\_\_\_\_\_

Employee Identification Number

\_\_\_\_\_

Date

\_\_\_\_\_

Work Location

\_\_\_\_\_

City

**APOC National Office Portion:** Upon employee request for representation APOC will sign and date this portion of the consent and fax it directly to Sun Life.

**For Quebec Residents &/or French speaking Members: Fax – 1-866-639-7846**

**All Other Members: Fax -1-866-209-7215**

**Cameron Clay**, 2<sup>nd</sup> National Vice President, APOC, 613-727-1310  
28 Concourse Gate, Unit 1, Ottawa ON K2E 7T7

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Representative Signature

\_\_\_\_\_

Date