Kentriki Insurance

HEALTH DATA PROCESSING CONSENT FORM

With the present, I hereby authorize Insurance Company "Kentriki" Limited (hereinafter referred to as "Kentriki Insurance"), to refer to doctors, health professionals, clinics and other health care providers who have occasionally monitored or treated me and/or the Dependent Persons who may be included in the insurance proposal and contract, as well as to other insurance companies in which I and/or the Dependent Persons have from time to time applied for insurance coverage, and to collect the necessary medical information concerning my physical or mental condition and/or physical and mental status of the Dependent Persons for the purposes of the application for insurance as well as for the management, service and execution of the insurance contract through which insurance coverage is provided by Kentriki Insurance.

With the present, I also hereby authorize the above-mentioned doctors, health professionals, clinics, other health care providers and insurance companies to provide Kentriki Insurance with the necessary medical information that will be requested from them for the purposes described above.

Furthermore, I have been informed that in case I wish to withdraw my or the Dependent Persons' consent for the processing of my or the Dependent Persons' personal data, this can be done either by a written notice sent to 33 Klimentos Str., Kentriki Tower, 1061 Nicosia, Cyprus or via email to andria@kentriki.com.cy. I understand that in case of withdrawal of my consent, Kentriki Insurance may not be able to provide me and/or the Dependent Persons with their insurance services.

	Full Name	**Signature**
Insured:	_____	_____
Dependent:	_____	_____
Dependent:	_____	_____
Dependent:	_____	_____

Date: _____