**NOTE: A SEPARATE FORM MUST BE COMPLETED FOR EACH PERSON AGE EIGHTEEN (18) OR OLDER**

In the event that you wish to have someone other than yourself (or your employer) contact Allegiance regarding your flex account, please complete this form. The form will not be accepted without notarization. Thank you.

## AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL AND CLAIM INFORMATION FOR FLEX/HRA ACCOUNTS

Name of Employer Plan: ______________________________ Group Number: ______________

Name of Covered Person: ______________________________ Social Security Number: ______________

Name(s) of Dependent(s) Birth Date(s) of Dependent(s)

__________________________ __________________________

__________________________ __________________________

__________________________ __________________________

__________________________ __________________________

As the Covered Person under the employee health and welfare benefit plan shown above, I hereby authorize Allegiance Benefit Plan Management, Inc., to release confidential medical and/or claims information to ______________, whose relationship is ______________ to the Covered Person listed above.

I agree to indemnify and hold the Plan Supervisor harmless for confidential medical and/or claims information released to the named individual based upon this authorization. This signed authorization will remain in effect until affirmatively revoked by me in writing. This authorization may be revoked at any time by sending written notice to the third-party claims payor, except that this authorization cannot be revoked retroactively after action has taken place, such as releasing information to the above named person, in reliance on the authorization.

______________________________________ ____________________

Signature of Covered Person Date

STATE OF _____

COUNTY OF ______________

Signed and acknowledged by __________________________ who provided proof of identification and who personally appeared before me, a Notary Public, this _____ day of ______, 20____ .

(SEAL)

______________________________

Signature of Notary Public

My commission expires ____________

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