AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH AND CLAIM INFORMATION

has requested health and/or claims information concerning claims submitted and paid for the covered person(s) shown below. Because laws exist to protect the privacy of confidential health and claims information, we need valid authorization from you, the Covered Person, to disclose this information to the requesting party. Please sign the following form in the presence of a Notary Public and return the completed form to the Plan's claim processor at the address listed on your identification card. Name of Employer Plan: Group Number: Name of Covered Person: Social Security Number of Covered Person: Name of Dependent(s)/Birth Date As the Covered Person under the above-named group health plan. I hereby authorize the Plan's claim processor to release the following confidential health and claims related information: This information may be disclosed to: ______, at the following address, _____, whose relationship to the Covered Person is: , for the following purpose(s): _____ To determine eligibility for benefits, enrollment in a group health plan, or for underwriting determinations: For payment of provider claims;

• ____ Other: ____

I agree to indemnify and hold the Plan Supervisor harmless for confidential health and/or claims information released to the named person(s) based upon this authorization.

This authorization will remain valid until the Covered Person is no longer covered under the above-named group health plan, for two years or until the following date: ______, whichever occurs earlier.

I understand I may revoke this authorization at any time, upon written notice to the Plan's claim processor at the address on my identification card unless either: 1) The Plan's claim processor has already disclosed my confidential information in reliance upon this authorization; or 2) this authorization was a condition of my enrollment in the group health plan.

I understand that the Plan's claim processor may not condition treatment, payment of claims, enrollment in a group health plan or eligibility for benefits upon this authorization, UNLESS this authorization is expressly for the purposes of determining eligibility for benefits, enrollment, or for underwriting or risk rating determinations.

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I understand that any confidential health and/or claims information disclosed to the requesting party in accordance with this Authorization may be re-disclosed by the requesting party and at that point, would no longer be protected by this Authorization.

		Signature of Covered
Person	Date	-
STATE OF	_	
COUNTY OF		
Signed and acknowledged by before me, a Notary Public, this _	day of	who provided proof of identification and who personally appeared, 20
(Seal)		Signature of Notary Public

My commission expires _____.

Please return this form via Fax or mail. Fax: 406-523-3111 Allegiance Benefit Plan Management, Inc., PO Box 3018, Missoula, MT 59806

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