AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR CUSTOMER SERVICE

(Optional Authorization -You are not required to sign)

Please clearly print all information.

For the purpose(s) of customer service and related activities, I hereby agree, on my behalf and on behalf of my dependents, that information available regarding coverage or any claim regarding me or my dependents may be released by Benefit Consulting Group, Inc. to me, my spouse, my dependents age 18 or over, my medical providers, my plan sponsors/employers, my agent(s) of record, as applicable, or as may be otherwise lawfully permitted, or as I may further authorize in the box below.

OPTIONAL Additional Authorized Individuals -Please print clearly.

I additionally authorize the following individual(s) to receive the above-named information,

_____ _____

Full Name (printed clearly) Relationship to customer

_____ _____

Full Name (printed clearly) Relationship to customer

Please Note: An authorization is not needed for disclosures related to my or my dependents' treatment, the payment for such treatment, or related health-care operations as defined under 45 CFR parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the authorized recipient and may no longer be protected by state or federal law. This authorization does not apply to psychotherapy notes.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire 15 months after the termination of any coverage I obtain (In Georgia and Texas, 24 months from the signature date). I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. I understand that I may refuse to sign this authorization. Should I choose to sign this authorization, I understand that I have the right to request access to my protected health information that may be used or disclosed.

Information Needed To Identify Your Plan:

Primary Customer Social Security Number: _____

Primary Customer Name Printed Clearly: _____

_____ _____

Customer Signature Date

_____ _____

Spouse Signature (if spouse is covered) Date

Signature of each Covered Dependents age 18 and over

_____ _____

Dependent Signature (if dependent is covered) Date

If signed by a legal representative of customer, please indicate the legal representative's authority to act on behalf of customer.

_____ _____

Legal Representative Signature Authority Date

For copies of this authorization, call (989) 773-6981. You may fax authorizations to (989) 772-1855 or mail them to General Agency Company, 525
East Broadway, Mt. Pleasant, MI 48858

Group Number Certificate Number

For office use only,