ELECTRICIANS HEALTH AND WELFARE PLAN, IBEW 995("THE PLAN")

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION

I, ______________________________, hereby authorize the Plan to use or disclose my health information as described in this authorization.

(1) Specific description of the health information I authorize to be used or disclosed:

ANY & ALL INFORMATION TO AID IN THE PROCESSING MY MEDICAL CLAIMS.

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(2) Specific person(s) or class of persons to whom the Plan may disclose the health information for their use:

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(3) Purpose of the request (either check "At my request" or state the reason):

☐ At my request, **or** for the reasons stated below:

FOR THE PURPOSE OF PROCESSING & PAYING MY MEDICAL CLAIMS.

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(4) I understand that this authorization will remain in effect until the date on which I have ceased being a Participant in the Plan for one continuous year unless I state below a different termination time or event, or until I file a written revocation:

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(5) *Right to revoke:* I understand that I have the right to revoke this authorization at any time by written notification to the Plan at the address listed below. I also understand that a revocation is effective only after it is received and logged by the Plan. I understand that any use or disclosure made under this authorization before it is revoked will not be affected by my revocation.

(6) I understand that the Plan will not condition treatment, payment, enrollment or eligibility for benefits on my providing this authorization.

(7) I understand that after health information is disclosed under this authorization, federal privacy rules may no longer protect it, and the recipient might disclose it again.

(8) I understand that I am entitled to a copy of this signed authorization.

____

Signature of Participant/Beneficiary or Personal Representative

Date:
Print Name: ________________________
Address: __________________________
____
Telephone Number: __________________
Social Security Number: ________________

Name & Social Security Number of Employee/Retiree if different from above:
Name______________________________ **SS#**______________________________

If signed by a Personal Representative, the Personal Representative warrants that s/he is authorized to sign on behalf of the Participant/Beneficiary based on the following authority:

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AUTHORIZATION MUST BE FILED WITH THE FOLLOWING PERSON:

Administrative Manager
Electricians Health and Welfare Fund, IBEW 995
8111 Tom Drive
Baton Rouge, Louisiana 70815
phone: (225) 927-6340 or (800) 324-0995
fax: (225) 927-6344

Notes (for Fund Administrator only):