

AUTHORIZATION RELEASE

I hereby certify that I am a participant in the EMPLOYER NAME Med Plan 2000 health benefits program. I understand that benefits are provided under this program by EMPLOYER NAME and its primary health carrier. I understand that ASI of Fresno, California administers portions of the health benefits provided by EMPLOYER NAME

I further understand that ASI may obtain data that could be construed as “Confidential” or ‘Private ‘and therefore authorize ASI to use its best effort to limit the disclosure of information to the ‘minimum necessary ‘to accomplish the intended goal of the plan.

I authorize ASI to release to my employer the information contained in the Med Plan 2000 documents for the purpose of administering the reimbursement portion of Med Plan 2000 health benefits program which is the fiduciary obligation of EMPLOYER NAME as established under the med Plan 2000 Plan Documents.

I agree this authorization shall be valid for the duration of EMPLOYER NAME and Med Plan 2000 health benefits program. And, in the event of a termination of the Med Plan 2000 health benefits program, for a period of time not less than 90 days from the date of termination and not longer than the grace period of Med Plan 2000 plan as designated by EMPLOYER NAME

Please sign and date this form and return it to your Benefits Coordinator.

Employee Name (please print)

Employee Signature

Date

I further understand that at times I may be reimbursed directly from Blue Shield for claims that may have been paid in part by my employer. If that happens, I may owe those reimbursements to my employer in part or full. By signing below I will inform my employer of any reimbursement I receive and understand that I must reimburse my employer for any amounts they have paid that gets reimbursed by Blue Shield.

Employee Signature