AUTHORIZATION RELEASE

I hereby certify that I am a participant in the my employer Medical Expense Reimbursement Plan. I understand that reimbursements for eligible medical expenses are provided under this program by my employer and its primary health carrier. I understand that ASI of Fresno, California administers portions of the reimbursement provided by my employer.

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 Medical Expense Reimbursement Plan documents for the purpose of administering the reimbursement portion of Medical Expense Reimbursement Plan which is the fiduciary obligation of my employer as established under the Medical Expense Reimbursement Plan Plan Documents.

I agree this authorization shall be valid for the duration of the Medical Expense Reimbursement Plan. In the event of a termination of the Medical Expense Reimbursement Plan, for a period of time not less than 90 days from the date of termination and not longer than the grace period of Medical Expense Reimbursement Plan as designated by my employer, the plan shall remain in effect for eligible reimbursements during the plan year.

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

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Employee Name (please print)

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Employee Signature

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Date