Plan Administration, LTD

OPTIONAL AUTHORIZATION TO DISCLOSE INFORMATION TO THIRD PARTY

You are not required to sign this Optional Authorization Form. However in order to reduce the time it takes and to better assist you with the adjudication of your claim(s) and to keep you promptly advised, we recommend completing the information below. Please sign and date as indicated below and send along with the necessary claims papers.

To assist in the administration of my claim, I authorize Plan Administration, LTD, and/or its subsidiaries and duly authorized representatives that they are provided with such information concerning but not limited to the status of my claim(s). I also authorize that you leave messages as to the status of my claim via Plan Administration, LTD voice mail, fax or e-mail.

I understand that the disclosure of information to Plan Administration and/or its subsidiaries and duly authorized representatives may not include disclosure of protected health information under HIPPA and the accompanying regulations.

I understand that any such information forwarded to Plan Administration, LTD will be used for the purpose of assisting me with the standing of my claim(s).

This Authorization is valid from the date signed for the duration of the claim, and may be revoked by me at any time upon written request to the address as indicated. A reproduction of this Authorization shall be considered as valid as the original.

________________________ _______________________________________

Date Insured/Employee Signature

(If the Insured/Employee is unable to sign, an authorized person may sign)

________________________ _______________________________________

Date Authorized Person Signature

Description of Authorized Person's authority to sign on behalf of the Insured/Employee:

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580 Hazard Avenue, Enfield, CT 06082, Phone (860) 272-1135, Fax (860) 242-1136