MEDICAL BENEFITS MUTUAL LIFE INSURANCE CO.
MEDICAL BENEFITS ADMINISTRATORS, INC.
MEDBEN MARKETING SERVICES, INC.
VISIONPLUS OF AMERICA, INC.
("MedBen")

AUTHORIZATION FORM FOR USES AND DISCLOSURES OF INSURED INFORMATION

I hereby authorize the use or disclosure of individually identifiable and/or personal health information about me as described below.

1) This authorization was prepared (check as applicable):

☐ At the request of the Covered Person
Name and SSN: _____

☐ At MedBen's request for the following purpose: _____

_____

☐ Other _____

2) If the authorization is to permit the use or disclosure of the insured's information for marketing, indicate whether MedBen will receive any remuneration or payment from a third party as a result of the marketing: No

3) Describe fully the information that is the subject of this authorization and which will be used or disclosed as set forth below:

_____

_____

_____

_____

4) Complete one of the following:

a. The following person(s) or group of persons employed or working for MedBen may use my personal health information which is described above:

_____

_____

b. MedBen may release my personal health information which is described above to the following person(s) or group of persons:

_____

_____

5) If you are the personal representative of a Covered Person, describe the scope of your authority to act on the insured's behalf and attach any substantiating documentation:

_____

_____

_____

6) I understand that if the person or entity that receives the above information is a not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

7) As described in the applicable **Notice of Privacy Practices**, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization, by sending a written revocation to Chief Privacy Officer at the address shown one the Notice of Privacy Practices.

8) This authorization will expire (enter specific date or event that we terminate the authority given under this Authorization): _____

_____

9) I understand that I am not required to sign this authorization form and that my group health plan will not condition the provision of payment on the signing of this authorization, except that the group health plan may condition enrollment in the health plan or eligibility for benefits on provision of this authorization, if: a) the authorization sought is for eligibility or enrollment determinations relating to me; or b) for underwriting or risk rating determinations.

_____
Covered Person Name

_____
Name of Covered Person's personal representative, if applicable

_____
Relationship of personal representative to Covered Person

_____
Signature of Covered Person (or Covered Person's personal representative) & **Date Signed**

_____
Signature of MedBen representative & **Date Signed**

PROVIDE COPY OF THIS FORM TO THE COVERED PERSON OR COVERED PERSON'S REPRESENTATIVE.