Authorization for Release of Insurance Information

Employer Name ___________________________________

MEDICAL MUTUAL OF OHIO is authorized to release claims and/ or benefits information contained in the Explanation of Benefits (EOB's) about me and my dependents, if any, enrolled under identification number _______________ (*the ss # of "eligible employee*") to my employer's administrator, Employee Benefit Concepts, Inc., for the express purposes of tracking health, or dental, or vision benefit expenses and/ or administering the partial self-funding of benefits. I / we also authorize Employee Benefit Concepts, Inc. to share such information, as needed, at their discretion, with the Insurance Agent of Record who may be assisting in the administration of the partial self-funded benefits.

As the "eligible employee", I understand that, as a result of this authorization, the administrator will receive copies of the Explanation of Benefits and other information which may contain confidential information regarding the providers that I have seen and the amount that has been spent on my care. This authorization shall be honored continuously from the date of signature.

In addition I authorize providers of medical services to release medical information which will aid in the administration of partial self-funded benefits.

If I elect not to authorize the release of the above information, I understand that it will result in claims that cannot be reimbursed under my employer's medical reimbursement plan.

SIGNATURES REQUIRED

_____________________________ **Signature of Eligible Employee**

_____________________________ **Signature of Spouse (Required, if to be insured)**

____________ Date

____________ Date

Signature of Dependent Child (Children) Age 18 or over (Required, if to be insured)

[_________________ Date ____] [_________________ Date ____] **[** _________________ Date ______]

Employee Name ______________________________ Telephone _____--______--___________
(First, Last)

Address ______________________ City __________________ Zip __________State ____________

Social Security Number ____________________ Date of Birth _____________ Date of Hire ___________

Dependents	Name (First, Last)	Social Security	Date of Birth
Spouse			
Child			
Child			
Child			
Child			
Child			

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