



FORM # 3
REQUEST OR RELEASE OF INFORMATION

PHYSICIAN(S), HEALTH CARE PROVIDERS, HOSPITALS

Third Party Requests: I authorize the SGEU LTD Plan and/or the Plan's medical adjudicator, and/or any of its agents or representatives, to release or share any relevant personal, health, or medical and/or claim information including, but not limited to the status, benefit period, medical documents, or vocational/RTW (return to-work) reports and/or any other information deemed necessary for my physician(s) or other health care provider(s).

SGEU LTD Requests: I authorize the SGEU LTD Plan, and/or the Plan's medical adjudicator, and/or any of its agents or representatives, to collect, use or disclose any relevant personal, health or medical information from my physician(s), health care provider(s), hospitals, or treatment facilities including, but not limited to assessments, diagnostics, consultations, treatment, or vocational/RTW (return to-work) reports and/or any other information deemed necessary for the administration of my LTD claim.

Information may be discussed with any agent or representative of the third party or the SGEU LTD Plan via telephone, written correspondence, or by any other communication mediums.

I understand that it is my responsibility to notify the SGEU LTD Plan of any changes regarding this authorization and the SGEU LTD Plan is not responsible for the effect of this authorization.

This authorization shall remain valid for the duration of my LTD claim unless revoked in writing by myself or by my designated Contact Representative as per Form # 2. Any photocopy or electronic copy of this authorization shall be as valid as the original.

Member Authorization

Date: _____

Member's Name (Printed): _____

Member's Signature: _____