RELEASE OF INFORMATION

FORM NO. 1

Group Life, Extended Health & Dental

I hereby authorize the release of any information regarding my group life insurance plan and extended health and dental insurers, requested by the life and extended health and dental insurance company or any successor administering said group life plan.

_____
Member's Name

_____
Signature

_____
Date

This authorization shall remain valid for the duration of my claim for benefits unless previously revoked, in writing, by me or my representative signing this form. Any photocopy or electronic copy of this authorization shall be as valid as the original.