RELEASE OF INFORMATION

FORM NO. 2

Representative

I hereby authorize and direct the SGEU Long Term Disability Plan and/or the plan's medical adjudicator to release to:

Name (Spouse/Family/Other)	Telephone Number
______________________________________	__________________
______________________________________	__________________
______________________________________	__________________

Any SGEU LTD Plan benefit or medical information which may have been acquired during the course of my Long Term Disability Plan claim.

____
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.

06/2015