RELEASE OF INFORMATION

FORM NO. 3

Health Care Provider

I hereby authorize and direct that any Physician; Surgeon; Hospital, and/or any other Health Care Provider; ***who has examined or treated me*** - to release to the SGEU Long Term Disability Plan and/or the plan's medical adjudicator **any information** which may have been acquired in the course of such examination or treatment.

I understand that this information is to be used for the sole purpose of my application for and receipt of SGEU Long Term Disability Plan benefits.

_____
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.