

**RELEASE OF INFORMATION**

**FORM NO. 6**

**Advocate**

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

**ADVOCATE,** \_\_\_\_\_,

to be used for the sole purpose of advocating on my behalf through the appeal process of the SGEU Long Term Disability 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.