AUTHORIZATION FORM TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS

Federal privacy law limits the ability of the Heartland Health & Wellness Fund (the "Fund") to disclose your health information to others, including to your family members. The privacy law requires that every adult covered person must give a written authorization before we may disclose your health or medical information to another person, including to family members such as a spouse. If an authorization is not on file, the Plan can disclose such information **only** to the covered adult person to whom the information relates.

If you would like to authorize the Fund to disclose your health and medical information to your family members, then please complete and return this form to the Fund. This will authorize the Fund to disclose information regarding your medical treatment and health benefits coverage to your family members. To obtain additional copies of this form, contact the Fund.

Employee-Participant Information

FULL NAME (EMPLOYEE-PARTICIPANT)	SOCIAL SECURITY NUMBER	DAYTIME PHONE NUMBER

STREET ADDRESS	CITY	STATE	ZIP

ATTENTION ALL PERSONS 18 YEARS OR OLDER COVERED UNDER THE FUND. If you would like the Plan to be able to disclose your health and medical information to your family members, please read this Authorization Form carefully and then check all below that apply and sign after each statement you check:

☐ I am the Employee-Participant and I authorize you to disclose to my spouse _____
spouse name

Signature _____ Date Signed _____

☐ I am the Spouse of the Employee-Participant and I authorize you to disclose to my wife/husband.

Signature _____ Date Signed _____

☐ My name is _____ and I authorize you to disclose to

_____
Name(s) and relationship

Signature _____ Date Signed _____

☐ I am a Dependent Child age 18 or older. My name is _____ and

I authorize you to disclose to _____
Name(s) and relationship

Signature _____ Date Signed _____

By signing above, I have authorized the Fund to disclose my health information as described in this authorization. I have had an opportunity to review and understand the contents of this form and I am confirming that it accurately reflects my wishes.

Description of Information to be Disclosed by the Fund. I understand that this authorization permits the Fund to disclose to my designated family member(s) **all** information created or received by the Plan related to my medical treatment, health conditions, eligibility for health benefits and/or payment of health benefits by the Plan UNLESS I check the following box to limit the information that will be disclosed:

☐ I do NOT want all of my information to be disclosed to my designated family member(s). Instead, I hereby authorize the Fund to release only the following specific information:
_____.
Name of person to whom this restriction relates: _____.

Expiration of Authorization. This authorization will expire three years from the date it was signed, or, if earlier (1) upon the termination of my coverage under the Fund, (2) as to a person who has authorized disclosure to his/her spouse, upon the dissolution of marriage, (3) when I revoke the authorization in writing or (4) as of the following date or event: _____.

Right to Revoke. I understand that I have the right to revoke this authorization at any time by notifying the Fund Office in writing at: 7250 Poe Avenue, Suite 300, Dayton, OH 45414. I further understand that the revocation is effective only after it is received at the Fund Office and that any use or disclosure made prior to the revocation will not be affected by the revocation.

Voluntary. I understand that I am under no obligation to sign this authorization form. I acknowledge I am voluntarily signing this form to release my health information to the party I have designated.

Benefits Not Conditioned on Authorization Form. I understand that eligibility for benefits is not conditioned on this authorization form unless I am not yet enrolled in the Fund and the purpose of this authorization form is to allow the Fund Office to obtain information it needs to make an eligibility, enrollment or underwriting determination.

Potential for Redisclosure. I understand that after my health information is disclosed, federal law might not protect it, and the recipient might redisclose it.

Right to Copy. I understand that I am entitled to receive a copy of this authorization.

Photocopy and Facsimile. A photocopy or facsimile of this signed authorization form shall be considered as valid as an original signed copy.

Purpose of Disclosure. This form authorizes the Plan to disclose my personal health information to the person(s) designated pursuant to my individual request.