

AUTHORIZATION FORM

(For Use or Disclosure of Protected Health Information)

PURPOSE OF THIS FORM

In order for the National I.A.M. Benefit Trust Fund ("Fund") to use or disclose your Protected Health Information to someone other than you, you must complete this Authorization Form and return it to the Fund.

Protected Health Information ("PHI") is information that is created, received, transmitted or stored by the Fund which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, the Fund may not use or disclose PHI to persons other than those you specify on this form.

The Fund may request that you complete this form where the use or disclosure of information is necessary to carry out functions of the Fund. In addition, you may submit this form to the Fund because you want someone, such as your spouse or union representative, to request or receive your PHI from the Fund. This form is not needed if you are requesting your own PHI from the Fund. All sections of this Form must be completed.

Name of Individual Giving Authorization (Please F	Social Security Number					
If you are a dependent of a covered employee/mem the covered employee/member.	nber, please provid	de the name and Social Security Number of				
Name of Covered Employee/Member	Social Security Number					
PART I: Authorized Person(s)						
I authorize the Fund to disclose my protected heal following person(s):	th information (P	HI) identified in Part II of this form to the				
1. Name:	Relationship:					
Address:						
2 37						
Address:						
PART II: Description of the information to be u	sed or disclosed					
I authorize the Fund to disclose my protected hear information) to the person(s) identified in PART I want different people to have access to different information.	of this form in co formation, you mu	nnection with (mark all that apply): (If you				
All Claims information for any dates of servi		_				
Medical Claims only for the following dates:						
Dental Claims only for the following dates:		To:				
Vision Claims only for the following dates:		To:				
Specific Medical, Dental, Vision, or Other Claim for Health Benefits (as noted below):						
Provider:						
Date(s) of Service: Other (please be as specific as possible):						

PART III: Purpose of use or disclosure

	purpose(s) for which the individual(PHI is as follows: (mark all that apply		ned in Part I of this Authorizati	ion Form	may have access to			
	Health care claims or appeals Coordination of benefits Eligibility in the Fund Subrogation and reimbursement Other purpose (explain):		Payment for health care Health care claim status Premiums and co-payments I am requesting disclosure of I	PHI for my	Coverage Preauthorization y own purposes			
	RT IV: Effective Period of the Form		decimantal halana (aharbaraha	L	:6ll			
This Authorization Form is valid for the period designated below (check only one box; if you check more than one box, the Authorization Form will be valid only for the shortest period selected):								
	For as long as I am eligible for benefits under this Plan							
	Only until the information requested on this form is provided to the individual identified on this form.							
	Until:		(p	lease prov	vide a date or event)			
to the l	may also cancel this authorization at the Fund office a properly completed Fund office. RT V: Acknowledgment and Signat	Canc			•			
I un	derstand that:							
•	THE FUND WILL PROVIDE A COPY OF THIS SIGNED AUTHORIZATION FORM TO ME OR MY PERSONAL REPRESENTATIVE.							
•	I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION FORM.							
•	I HAVE THE RIGHT TO REVOKE THIS FORM AT ANY TIME BY SUBMITTING A CANCELLATION OF AUTHORIZATION FORM TO THE FUND.							
•	CANCELLATION WILL TAKE EFFECT AS OF THE CANCELLATION DATE OR EVENT, OR ONCE THE FUND RECEIVES THE CANCELLATION OF AUTHORIZATION FORM.							
•	THE PERSON(S) I AM AUTHORIZING TO RECEIVE MY PHI MAY NOT BE REQUIRED TO TREAT THIS INFORMATION AS CONFIDENTIAL.							
Yo	ur Signature (or Signature of Persona	l Repi	resentative*) Date					

^{*} If you are acting as the Personal Representative of the individual whose PHI is to be disclosed, you must provide proof of your authority to act for that individual.