AUTHORIZATION FOR RELEASE OF INFORMATION

MEDICAL PLAN CLAIM ADMINISTRATOR NAME

____

To the Medical Plan Claim Administrator Named Above, (the "Claim Administrator")

I hereby authorize the below designated individuals, who are duly designated representatives of the Communications Workers of America (CWA) to act on my behalf in connection with the benefit issue as described below:

PLAN: __ Short-term disability __ Concorde __ Long-term / Retirement Disability

__ Family & Medical Leave Act __ Other

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I authorize the Claim Administrator to release to the below designated CWA representative(s) and the Plan Holder, AT&T Inc., or its representative, (AT&T) any and all information and documentation requested by them which specifically relates to the benefit issue described above, including but not limited to medical or clinical information and documentation relating to the request **to the extent allowed by State and Federal law**. The below designated individuals agree to use this information and documentation solely for the processing of the request noted above, and agree that no information and documentation relating to this request will be released by them to any other party without my express written consent.

I hereby release the Claim Administrator from any claim that I might have against the Claim Administrator for releasing such information and documentation to the below designated CWA Representative(s) and/or AT&T.

I understand that both I and the below designated individuals may obtain a copy of this signed authorization form from the Claim Administrator. These authorizations shall be valid for the duration of the claim, or until the termination of the affected plan, whichever is sooner.

Designated/Approved CWA Representative(s) Name(s):

Elise Maloof (CWA Managed Care Specialist) ____________________ Date ____________________

Shane Peterson (CWA Claims Facilitator) ____________________ Date ____________________

James P. Centers (President - CWA Local 3611) ____________________ Date ____________________

Employee Signature (Necessary for the release of either employee or dependent information)

____ Date ____________________

Employee Social Security Number: ____

Spouse signature or Signature of Custodial Parent (if dependent involved)

____ Date ____________________

Authorization

RF-4101 (11-92)

TO:		From: James P. Centers, President – CWA Local 3611	
FAX Number	Telephone Number	FAX Number (919) 854-5442	Telephone Number (919) 851-3611
Subject			

I authorize the appropriate Claims Facilitator to assist in developing my claim/appeal for benefits under the Short-Term Disability Plan (STDP).

I further authorize the Claims Facilitator to review and share relevant records maintained by the Benefits Administration office pertaining to my claim for disability benefits with other appropriate persons outside the Benefit Administration office, including any authorized Union representatives, on a confidential and need-to-know basis

I understand that the Claims Facilitator is not authorized to make STDP interpretations or to make decisions regarding implementation or administration of the STDP

Employee's Signature: ____

Date: __________________________

Assists represented employees only