Authorization For Release of Information

I. Information About the Use of Disclosure

I hereby authorize the use or disclosure of all of my individually identifiable health information for my Health Care Reimbursement account with my employer listed below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to ASI.

Participant name: _____ Soc. Sec. or ID No.: _____

Participant's employer: _____

Person(s) authorized to receive the information: _____
_____
_____

This authorization will expire on _____ (indicate date).

II. Important Information About Your Rights

I have read and understand the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying ASI in writing, but the revocation will not have any effect on any actions ASI took before ASI received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my Health Care Reimbursement account benefits.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving person. I have the right to seek assurances from the above-named person(s) authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

III. Signature of Participant

_____ _____
Signature of participant Date

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Return this signed authorization to:
ASI
P O Box 6044
Columbia, MO 65205-6044