United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund
United Food and Commercial Workers Unions and Employers Midwest Pension Fund
18861 90th Ave., Suite A ♦ Mokena, IL 60448 ♦ 800-621-5133
FAX 847-384-0188 ♦ ufcwmidwest.org

Authorization for Release of Health Benefits Information to the Pension Fund

In the course of processing your pension request, the Pension Office may need to contact the Health Benefits Fund to verify hours for which contributions were paid on your behalf and/or periods when you were not working due to disability. This is done to ensure that you receive all credit available to you. Federal law now requires that every adult person must give a written authorization before the Health Benefits Fund may disclose information about your benefits to another person. If an authorization is not on file, the Health Benefits Fund cannot disclose information to the Pension Fund.

Please complete and return this form to us so that the Health Benefits Fund is authorized to disclose to the Pension Fund information regarding your health benefits coverage.

Employee-Member Information

FULL NAME (EMPLOYEE-MEMBER)	UFCW ID# or SOCIAL SECURITY NUMBER	DAYTIME AREA CODE/PHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP

By signing below, I have authorized the United Food and Commercial Workers Unions and Employers Midwest Health Benefits Plan to disclose my health benefits information as described in this Authorization. I have had an opportunity to review and understand the contents of this entire form and I am confirming that it accurately reflects my wishes:

I am the Employee-Member and I authorize you to disclose information to the United Food and Commercial Workers Unions and Employers Midwest Pension Fund.

Signature____Date Signed ______________________

Description of Information to be Disclosed by the Plan. I understand that the information that may be disclosed by the Plan will include all information created by or received by the Plan related to my eligibility for health benefits and/or payment of health benefits by the Plan.

Expiration of Authorization. This authorization will expire (1) upon the completed processing of my pension request; or (2) when I revoke the authorization in writing.

Right to Revoke. I understand that I have the right to revoke this authorization at any time by notifying the Benefits Fund Office in writing. I further understand that the revocation is effective only after it is received at the Benefits 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.

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.