Benefit Strategies, LLC
PO Box 1300
Manchester, NH 03105
(603) 647-4666
Fax: (603) 647-4668

AUTHORIZATION FOR RELEASE OF INFORMATION
Health and Dependent Care Spending Accounts

Must be completed for all authorizations

Participant Name: ______________________ Company: ______________________

Social Security Number: ______________________ Telephone: ( ) -

Please print clearly.

I hereby authorize disclosure of my Health Care Spending Account and/or Dependant Care Spending Account claims reimbursement information as described below. I understand that this authorization is voluntary. I understand that the released information may no longer be protected by federal privacy regulations.

Full Name of Person Authorized to Receive the Information: ______________________

Specific Instructions Pertaining to this Authorization: ______________________

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1. I understand that this authorization will not expire.
2. I understand that I may revoke this authorization at any time by notifying Benefit Strategies in writing.

Signature of Participant: ______________________ Date: ____________

Signature of Authorized Representative: ______________________

Relationship to Participant: ______________________ Date: ____________