Release of Health Information

Plan Name: _____

Employee Name: _____

Employee Address: _____

Employee SSN: _____

Claimant Name: _____

Claimant Date of Birth: _____

(If claimant is 18 years of age or older, this form must be signed by the claimant.)

I hereby authorize the above mention plan and/or American Trust Administrators, Inc to disclose to:

_____

any and all information in their possession regarding me or my health, or my dependents or their health. This information may relate to such items as employment or diagnosis, treatment, or prognosis, with respect to any physical or mental condition (including AIDS and related conditions and/or the presence of HIV virus), or use of drugs or alcohol. This authorization will be valid for a period of two years from the date signed. A photocopy of this authorization is as valid as the original, and I am aware that I have the right to receive a photocopy of this authorization if I request one.

_____

Employee/Claimant

_____

Date

_____

Witness

Mail completed form to American Trust Administrators, 7223 W 95TH Street Suite 301, Overland Park, KS 66212

AAR (9/02)