AUTHORIZATION TO RELEASE HEALTH INSURANCE COVERAGE/PREMIUM INFORMATION

Dear GFPS Employee or Retiree:

In the event that you wish to have someone in addition to yourself communicate with Great Falls Public Schools (GFPS) regarding your health insurance coverage and/or premium information, please complete this form. This form must be notarized. Notaries are available in the GFPS Human Resource Office. Please print:

Name of Employee or Retiree: _____

Phone number: _____

Social security number: _____

As the covered person under the Great Falls Public Schools' Cigna health care plan, I hereby authorize Great Falls Public Schools' personnel to release health insurance coverage/premium information to

_____*, whose relationship to me is* _____.

I agree to indemnify and hold Great Falls Public Schools harmless for insurance/premium information released to the named individual based upon this authorization. This signed authorization will remain in effect until affirmatively revoked by me in writing. This authorization may be revoked at any time by sending written notice to the GFPS Human Resource Office, except that this authorization cannot be revoked retroactively after action has taken place.

_____ _____

Signature of covered person **Date**

To be completed by Notary:

STATE OF _____

COUNTY OF _____

Signed and acknowledged by _____ who provided proof of identification and who personally appeared before me, a Notary Public, this ____ day of ____, 20__.

(SEAL)

_____
Signature of Notary Public
My commission expires _____

Please send this completed form to:

Great Falls Public Schools
Attn: Human Resources Office
PO Box 2429
Great Falls, MT 59403