RELEASE OF MEDICAL INFORMATION

By signing this form, I authorize my physician, medical professional, hospital, clinic, or other medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or my health, or my dependents or their health, to give such information to Healthgram, Inc., if requested.

NOTICE OF ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents, (including your spouse) because of other health benefit plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you do not enroll for yourself or your dependents within 30 days after your coverage ends, you may enroll as a Late Enrollee. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Are you declining enrollment for yourself or your dependents because you or your dependents have coverage under another health plan? __Yes __No

By signing this document I agree to all the terms contained herein.

_____ _____

Employee Signature Date