TAXSAVER PLAN AUTHORIZATION RELEASE FORM:

Participant Name:____________________________________ Social Security Number (last 4):___________

Address:____

____

Home Telephone Number:___________________________ Work Telephone Number:____________________

Participant Date of Birth:_____________________________ Name of Employer:_________________________

I hereby authorize disclosure of my health and/or plan information (including information that constitutes Protected Health Information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) in the manner described below. **I understand that I am under no obligation to sign this form and that my refusal to sign will not affect my ability to participate in my Employer's benefit plans.**

I hereby authorize TaxSaver Plan to disclose my private health and/or plan information to the following person(s):

Name:____ Relationship:_____________________

Name:____ Relationship:_____________________

Participant's Signature:_____________________________________ Date:___________________________

Please return completed signed form to:

TaxSaver Plan P.O. Box 609002 Dallas Texas 75360 Fax: 214-528-8122 Email: csr@taxsaverplan.com