

Employee:  
Employee ID# :  
Claimant Name:  
Provider:

Dear Employee:

Your claim for benefits has been received and carefully reviewed.

Please complete the authorization below.

#### AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any hospital, physician or other person who has attended me or examined me or my dependents, to disclose, when requested to do so by Line Construction Benefit Fund (Lineco) or its representatives any and all information with respect to any illness or injury, medical history, consultation, prescription or treatment, and copies of all hospital or medical records.

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(PATIENT, OR PARENT OR GUARDIAN  
IF A MINOR CHILD)

Call Lineco @ 1 (800) 323-7268 and ask for a claim service representative.

Sincerely

Claim Department