

**Group Executive Insurance Marketing, Inc.
Disclosure Form**

I authorize Group Executive may disclose my protected information to the following persons, of who is directly involved in my health care.

- | | |
|----------|----------|
| 1) _____ | 2) _____ |
| 3) _____ | 4) _____ |
| 5) _____ | 6) _____ |

I acknowledge and agree that Group Executive may disclose my protected health information to persons set forth in this form and until I object to such disclosures, which must be provided in writing to Group Executive. I further acknowledge and agree that I am not required to complete or execute this form.

Date: _____

Signature of the covered employee

Print Name of covered employee