Employee's Authorization to speak with someone who is not an active dependent under the plan.

Please print all information except the signature.

Employee's id #(social security number)______________________. Group #________. Date_____________

I, ____(employee)

Give Commerce Benefits Group, authorization to speak with

____, Relationship to the

employee ____________________________________.

Signature of the employee:______________________________________

Date signed: ____

Please mail this form to Commerce Benefits Group, P.O. Box 900, Elyria, OH 44036

Attention Eligibility Department

Or fax to (440) 930-7501 the attention of the Eligibility Department.

If you have any questions on completing this form, please call 1(800) 223-9941 and our Customer Service Department may assist you.