# AUTHORIZATION TO PROVIDE EMPLOYEE BENEFIT INFORMATION

So that I can fully understand my current insurance and employee benefit program (both personal and employer provided), I authorize you to provide the information below to ______________________, who is acting as my insurance and financial advisor in these matters.

**Group Health Insurance** None

Major Medical HMO Other Carrier: ______________________

Coverage Description: ______________________

**Group Life Insurance** None

Flat Dollar Amount: $ ________ Multiple of Salary: ____ times Annual Salary or $ ________

Other Details: ______________________

**Disability Income Insurance** None

Short-Term Disability Long-Term Disability Details: ______________________

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**Long-Term Care Insurance** None

Daily Benefit Amount- Nursing Home/Home Care: $________ / $________ Benefit Period(s): ________

Elimination (Waiting) Period(s): ________ Other Details: ______________________

**Cafeteria Plan Benefits** None

Details: ______________________

**Retirement Plan Benefits** None

Pension Plan: Details: ______________________

Profit-Sharing Plan: Details: ______________________

401(k) Plan: Company Match? Y N If Yes, Maximum %: ____ Other Details: ________

______________________

Deferred Compensation Plan: Details: ______________________

Other Retirement Plan(s): Details: ______________________

If you have any further questions, please contact my advisor at the number listed below or contact me directly. Thank you for your help.

Client Name: ________________ Client Signature: ________________

Advisor Name: ________________ Advisor Signature: ________________

Advisor Phone Number: ________________ Date: ________________