CEBT
Benefit by Trust

CEBT HIPAA RELEASE FORM

I authorize _____to talk to the Willis of Colorado staff regarding claims and benefits for the following covered members.

This authorization covers the duration of my coverage, and after coverage terminates, as it relates to any issues with my claims and benefits, unless I revoke it in writing by notifying Willis of Colorado.

_____

_____

_____

_____ _____
Member's Name (Print) Date

_____ _____
Member's Signature Member ID Number