AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I authorize the Union Pacific Group Health Plan (including the Plan's Business Associates administering such Plan) (the "Plan") to use or disclose my individually identifiable health information as described below:

_____
(Employee Name & ID Number)

_____
(Participant's Name and Employee ID Number if not Employee)

Describe the information to be used/disclosed by the Plan:
_____
_____

Persons/organizations authorized to receive the information from the Plan: (Select the following option or enter your own description below.)
__ Union Pacific HR Service Center and Union Pacific Benefits group
__ Other persons/organizations: _____
_____

Indicate the purpose of the use or disclosure: (Select one of the following options or enter your own description below regarding why the authorization is being provided.)
__ At the request of the participant.
__ To obtain Union Pacific's assistance in resolving a question or claim concerning my Plan benefits.
__ Other specifically described purpose: _____
_____
_____

Unless revoked earlier, this Authorization will expire: (Select one of the following options or enter your own description below.)
__ In 180days from the date below.
__ When the benefit question or claim for which the disclosure was requested is resolved.
__ Other: _____

I have read and understand the following statements about my rights:
- I may refuse to sign this Authorization.
- The Plan cannot condition my enrollment, eligibility, or payment of benefits on my signing this Authorization, except that the Plan may condition enrollment in the Plan or eligibility for benefits on provision of this Authorization if the Authorization sought is for the Plan's eligibility or enrollment determinations relating to me, or for the Plan's underwriting or risk rating determinations.
- I may revoke this Authorization at any time prior to its expiration date, provided that I do so in writing, but the revocation will not have any affect on any actions the Plan took before it received the revocation. In order to revoke this Authorization, I must fax a statement including the Employee Name and ID number or the Participant's name and Employee's ID Number, as applicable, to (402) 233-2736 or by mail to the Union Pacific HR Service Center, Attn: HIPAA, 1400 Douglas Street, Stop 0320, Omaha, NE, 68179. Any revocation is not effective until it is received by the Plan.
- The information used or disclosed pursuant to this Authorization may no longer be subject to federal privacy protections and may be disclosed by the recipient without my further authorization.

By: _____ Date: _____

If signing on behalf of the Participant as his/her legal representative:

By: _____ Date: _____
Name: _____

Description of Representative's Authority: (Parent of minor; Power of Attorney, etc.)

_____

_____

NOTE: THIS AUTHORIZATION FORM MUST BE COMPLETED IN ITS ENTIRETY BEFORE SIGNING BY PARTICIPANT OR PARTICIPANT'S REPRESENTATIVE. PLEASE FAX TO (402) 233-2736 OR MAIL TO THE UNION PACIFIC HR SERVICE CENTER, ATTN: HIPAA, 1400 DOUGLAS STREET, STOP 0320, OMAHA, NE, 68179.

PLEASE MAKE A COPY OF THE SIGNED AUTHORIZATION BEFORE SUBMITTING IT.