Medical Information Authorization

All doctors who treat me and all hospitals in which I have ever been a patient are hereby authorized to permit FutureComp/USI , or their representatives, to examine all records and X-rays and to give any and all information which they, or any physician appointed by them, may request regarding my physical condition and treatment (past, present or future), in connection with my presented claim for benefits. A photocopy of this authorization is to be given the same force and effect as the original.

Print name

Signature

Date: