EMPLOYEE GROUP INSURANCE
Revocation of Authorization

Name: ____

Date of Birth: ____

Social Security No.: _____________________________________

By my signature below, I hereby revoke (Check one):
(1) ☐ The authorization attached or of which a copy is attached
(2) ☐ The authorization for the access, use or disclosure concerning the records of the above named person dated _________ which was for (specify the information that was the subject of the authorization, the person authorized and the purpose of the authorization in sufficient detail to identify the authorization being revoked) ____
____

I understand that if Box (1) is checked, this revocation will not become effective unless the authorization or a copy of the authorization being revoked is attached.

Signature: ____ Date: ______________________________

If the revocation is signed by a legal representative of the individual:
Printed name of legal representative: ____
Representative's authority to act for the individual: ________________________________

This form should be delivered in person, by U.S. mail, or by facsimile to the following:

ATTN:

Manager of Insurance Benefits/Contact Person
Employee Group Insurance
702 Colorado Street, Suite 6.600
Austin, Texas 78701
FAX Number 512/499-4620

For EGI Use Only

Name of person processing request: ____________________________________

Title of person processing request: ____________________________________

Date revocation request received: ______________________

Revoked authorization form attached? ☐ Yes
☐ No