CONSENT

COLGATE UNIVERSITY ACCIDENT AND HEALTH PLAN

I hereby give consent to POMCO to use and disclose my protected health information for the purposes of payment of my claims (as defined by the Health Insurance Portability and Accountability Act of 1996) to the following person:

NAME: ______________________________________________________________________________

RELATIONSHIP*: Parent/Guardian/Spouse/Others (please specify) __________________________
*delete whichever is not applicable

This consent will terminate on: (circle one)

- August 1, 2010

- Other (specify by date or event) ________________________________________________________

I understand that at any time I have the right to revoke this consent provided that I do so in writing but that POMCO may still use information to complete actions that it began prior to revoking consent and which rely on my protected health information.

__________________________________________  ___________________________________
Member Name  (Please Print)                               Name of College

__________________________________________                 ___________________________________
Member  I.D.  Number                                                                Student  I.D.  Number

__________________________________________________________           ______________________
Signature of Member                  Date

Please Mail to:

POMCO
P.O. Box 186
Syracuse, NY  13206-0186