CareConnect
Healthier Insurance™

VIDEO TESTIMONIAL RELEASE CONSENT

Purpose of Consent: By signing this form (the "Release"), you are authorizing CareConnect Insurance Company, Inc. ("CareConnect") to use and disclose your video testimonial in its marketing and public relations efforts and acknowledge that the testimonial may be distributed to the media, other individuals and entities that may be involved in CareConnect's marketing and public relations efforts and the public.

Right to Revoke: You have the right to revoke this Release at any time by giving us written notice of your revocation and submitting it to the Marketing Department at the address or fax number listed below. Please understand that revocation of this Release will not affect any action CareConnect took in reliance on this Release before receiving your revocation.

CONSENT TO RELEASE

I hereby authorize CareConnect to copy, exhibit, publish, distribute or otherwise use and disclose my video testimonial and any information in the testimonial for purposes of publicizing its services and products, for any other marketing and public relations efforts or for any other lawful purpose. These statements may be used in printed publications, multimedia presentations, on websites or in any other distribution media. I understand and approve the disclosure by CareConnect of testimonial information to the media, the public and other individuals and entities that may be involved in CareConnect's marketing and public relations efforts.

I agree that I will make no monetary or other claim against CareConnect for the use of the testimonial. I waive the right of prior approval for the use of my testimonial and hereby release CareConnect from all claims for damages of any kind based on the use of my video testimonial or information provided within the video testimonial. I understand that health information once disclosed may be re-disclosed by the recipient, and this re-disclosure may no longer be protected by federal law.

I understand that signing this Release is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon signing this Release. I am at least 18 years of age and am competent to contract in my own name. I have read this Release before signing below and I fully understand the contents, meaning, and impact of this Release.

This Release will expire five (5) years from the date that it is signed.

_____ _____

Signature Print Name

_____

Date

Please provide your contact information:

_____
Name

_____ _____
Address City, State, and ZIP code

_____ _____
Email Phone

Please mail the completed form to:

CareConnect
Attn: Corporate Communications
2200 Northern Boulevard, Suite 104
East Hills, NY 11548

If you have questions, please contact Customer Service at (855) 706-7545**.**