

FirstEnergy Corp.
HEALTH AND WELFARE PLAN
HIPAA AUTHORIZATION

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PLEASE READ THIS DOCUMENT CAREFULLY

I Information About How Individually Identifiable Health Information Will Be Used or Disclosed In Accordance With This Authorization

I authorize the use or disclosure of individually identifiable health information described below. I understand that individually identifiable health information: (A) either identifies or reasonably may be used to identify the individual who is the subject of the information; and (B) includes information regarding an individual's physical or mental condition, health care and/or payment for health care. I have read this Authorization in its entirety, including the Section labeled "**Important Information About My Rights**," and hereby authorize the use or disclosure of individually identifiable health information described below.

A. NAME OF INDIVIDUAL WHO IS THE SUBJECT OF THE INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION:

B. SOCIAL SECURITY NO.:

C. THE FirstEnergy Corp. HIPAA-COVERED WELFARE PLAN IS AUTHORIZED TO USE OR DISCLOSE THE INFORMATION.

_____ (The Recipient) IS AUTHORIZED TO RECEIVE AND USE THE INFORMATION .

D. SPECIFIC AND MEANINGFUL DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED.

INFORMATION ABOUT MY CLAIM FOR BENEFITS RELATING TO:

OTHER (Please Specify)

E. PURPOSE OF THE USE OR DISCLOSURE:

ASSISTING ME IN UNDERSTANDING WHY MY CLAIM IS BEING DENIED AND, WHERE APPROPRIATE, ASSISTING ME IN GETTING MY CLAIM PAID

OTHER (Please Specify)

NOTE: "At the request of the individual" is a sufficient description if you requested this Authorization and you elect not to provide a statement of the purpose of this Authorization.

F. THIS AUTHORIZATION WILL EXPIRE (Check the Appropriate Box):

UPON RESOLUTION OF THE CLAIM FOR BENEFITS

UPON TERMINATION OF MY PARTICIPATION IN THE FirstEnergy Corp. HIPAA-COVERED WELFARE PLAN

UPON TERMINATION OF MY EMPLOYMENT WITH FirstEnergy Corp. AND ITS AFFILIATES

OTHER (Specify)

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II Important Information About My Rights

This authorization is voluntary and I may revoke this authorization at any time by submitting a written revocation to:

Attention: HIPAA Privacy Officer
FirstEnergy Corp. HIPAA-Covered Welfare Plan
76 South Main Street
Akron, Ohio 44308

The revocation will not have any effect on any actions taken before receipt of the revocation, as described in the FirstEnergy Corp. HIPAA-Covered Welfare Plan's Notice of Privacy Practices.

I may request to see and copy the information described in this Authorization in accordance with the procedures described in the FirstEnergy Corp. HIPAA-Covered Welfare Plan's Notice of Privacy Practices.

I am entitled to a signed copy of this Authorization.

I may refuse to sign this Authorization. Medical treatment, payment, enrollment in or eligibility for benefits under the FirstEnergy Corp. HIPAA-Covered Welfare Plan will not be conditioned upon my signing this Authorization.

The information that is used or disclosed pursuant to this Authorization may be redisclosed by the Recipient. Upon disclosure of the information to the Recipient, the information will no longer be subject to the privacy regulations under the Health Insurance Portability and Accountability Act.

III Signature of Participant (do not complete if personal representative)

This form MUST be completed before signing

SIGNATURE OF INDIVIDUAL

DATE

PLEASE RETURN FORM TO:

FirstEnergy Corp.
HEALTH AND WELFARE PLAN
HIPAA AUTHORIZATION

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IV Personal Representative (complete only if applicable)

This form MUST be completed before signing

By signing this Authorization, I hereby certify that I currently have the following authority for claiming to be a personal representative for the individual who is the subject of the individually identifiable health information (hereafter, the "Individual"):

- The Individual is an unemancipated minor child and I am his or her parent, legal guardian or other person with legal authority to act in place of a parent (in loco parentis) with respect to the Individual's health care. My status as parent/legal guardian/individual acting with legal authority permits me to make decisions relating to the Individual's health care.
- The Individual is an adult or emancipated minor child or I am his or her court-appointed guardian, have a power of attorney relating to the Individual's health care decisions, or otherwise have authority under applicable law to act on behalf of the Individual in making decisions related to his or her health care. The health information that is the subject of the Authorization is relevant to my personal representation of the Individual.
- The Individual is deceased and I am the executor, administrator or other person authorized under applicable law to act on behalf of the Individual or the Individual's estate. The health information that is the subject of this Authorization is relevant to my personal representation of the Individual or the Individual's estate.
- The Individual is a family member and I am authorized to act on their behalf. The health information that is the subject of this Authorization is relevant to my personal representation of the Individual.

RELATIONSHIP TO THE INDIVIDUAL WHO IS THE SUBJECT OF THE INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION DESCRIBED IN THIS AUTHORIZATION

SIGNATURE OF INDIVIDUAL

DATE

PRINT NAME OF PERSONAL REPRESENTATIVE