UBCP/ACTRA

RELEASE

I, _____ understand that if my Application is approved, an
(Member Name)

amount up to $_____ will be paid directly to _____
(Amount) (Treatment Facility)

as a payment towards the cost of in-patient or out-patient treatment. I waive any and all claims that I have or may in the future have against, and release from all liability and agree not to sue, UBCP/ACTRA and any of its employees, servants, agents, contractors, or representatives for any and all causes of actions, suits, contracts, claims, damages, losses, costs and expenses of any nature or kind whatsoever, that I may sustain as a result of any payment made pursuant to the **UBCP/ACTRA MEMBER ADDICTION MEMORIAL FUND POLICY** due to any cause whatsoever.

I also hereby give the treatment facility the right to inform UBCP/ACTRA if I do not complete treatment or if I leave the treatment program early.

_____
Member Signature

_____
Date