CONSUMER DRIVEN HEALTH PLAN NATIONAL ASSOCIATION OF LETTER CARRIERS



HEALTH BENEFIT PLAN

20547 Waverly Court, Ashburn, Virginia 20149 • (703) 729-4677 or 1-888-636-NALC (6252)

Fredric V. Rolando, President • Brian Hellman, Director



Designating an Authorized Representative

In accordance with the requirements of the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are sending you this important notice to let you know about our privacy policy and to give you – and your family members – an opportunity to name an Authorized Representative. When you designate an Authorized Representative, you are giving us permission to discuss your enrollment and claim-related information with that person.

As a health plan, we are permitted to disclose certain information to medical providers and our business partners as part of our daily operations. Permitted and required disclosures are outlined in our Notice of Privacy Practices. Generally, we will not release the protected health information of an enrollee or a family member age 18 or older – not even to a spouse, parent, child or friend who calls us at the enrollee's or family member's request – unless we have authorization on file.

Each family member age 18 or older that wishes to name an Authorized Representative must complete an authorization form. Enclosed are two forms and a postage-paid envelope. If you need additional forms, please photocopy this form, download it from our website: www.nalchbp.org, or call us at 888-636-NALC (6252).

You are not required to complete a form, but if you are an adult family member covered by the Plan and we do not have the caller's name on file as your Authorized Representative, we will not discuss your personal information, when someone calls on your behalf. You may want to designate an Authorized Representative even if you usually handle your own claims inquiries. That way, whether you call or an Authorized Representative calls for you, we'll be able to help. If the form is not filled out correctly or does not specifically identify the information to be disclosed, the form shall not be honored.

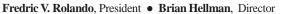
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HIPAA Privacy Rule Authorized Representative Form			
Member Name	Member # (as it appears on the Member Identification Card)		
Section A — F	Purpose		
This form allows to disclose your The information	s you (the "Individual") to give the NALC Consumer Driven Health Plan permission (authorization) protected health information (PHI) to a person that will act as your Authorized Representative. covered by this authorization is PHI, including identification of treating providers of care; cedures; and personal information, such as your date of birth and mailing address.		
Each adult family member, including each adult child (age 18 or older, or as determined by state law), who wishes to have someone act as their Authorized Representative must complete an authorization form. For example, if you expect your spouse to call us on your behalf, you need to fill out this form. You are not required to name an Authorized Representative, but if you do not, we will not release your PHI to someone who may contact us on your behalf. Your Authorized Representative may be anyone of your choosing, such as a spouse, parent, child, friend, congressman, or Union representative. If you need additional forms, you may copy this form, call us, or go to www.nalchbp.org.			
Please note: This authorization does not give your Authorized Representative authority, either implied or direct, over any treatment or direct care decisions. Also, we will not condition enrollment, eligibility for benefits, or benefits payments on your completion of this form. If this form is not filled out correctly and completely, it will not be honored.			
Section B — Individual's Information (Individual appointing an Authorized Representative)			
I authorize the NALC Consumer Driven Health Plan to treat the person(s) named in Section C as my Authorized Representative(s) as set forth therein.			
My Name	Date of Birth		
Daytime Phone	()Relationship to Member		
Section C — Authorized Use and/or Disclosure			
operations, or a my PHI to the pinformation discourse, are	at the Plan will not disclose my PHI, except for the purpose of treatment, payment, and health care is required by law, without my written authorization. For this reason, I authorize you to disclose person(s) named in Section C for the purpose(s) set forth herein. I understand that the closed pursuant to this authorization may no longer be protected by federal or applicable state and my Authorized Representative may further disclose my PHI without my authorization. I at my authorization is voluntary.		

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I understand that I have the right to limit the information you release under this authorization. For example, I may limit an Authorized Representative's access to information <u>only</u> about a particular provider or diagnosis/ disease; or I may allow an Authorized Representative access to everything except information from a particular

provider or about a particular diagnosis/disease. Any such limitations must be described below.

I authorize the NALC Consumer Driven Health Plan to release/disclose PHI as follows:			
Authorized Representative #1			
Full Name	Phone Number		
(please print)	_Phone Number		
Relationship to You			
Relationship to You(such as: spouse, parent, child, HBF	R, friend)		
Release the following information about me (check all that apply):			
Entire Claims Record Claims Record The following claim record (specify dates) of services			
For the purposes of (check all that apply):			
Further Medical Care	Personal		
Health Eligibility/Benefits	Changing Providers		
Legal Investigation or Action At my request	Other (specify):		
I authorize the NALC Consumer Driven Health Plan to release/disclose PHI as follows: Authorized Representative #2			
Full Name	Phone Number		
Full Name(please print)			
Relationship to You			
Relationship to You(such as: spouse, parent, child, HBR, friend)			
Release the following information about me (check all			
Entire Claims Record Claims Record fr The following claim record (specify dates) of services	rom (specify dates) to s, name(s) of provider(s), diagnosis, other information		
For the purposes of (check all that apply):			
Further Medical Care	Personal		
Health Eligibility/Benefits	Changing Providers		
Legal Investigation or Action At my request	Other (specify):		
Attach separate page to list additional Representative	s		

Section D — Expiration and Revocation			
This authorization to release information to my Authorized Representative will not expire unless you give an expiration date.			
This Authorization expires: Has no expiration			
I understand that I have the right to revoke or end this authorization at any time by giving written notice of my decision to the Privacy Officer at the address shown below. Simply submitting a new authorization form designating another Authorized Representative will not revoke this authorization. I understand that my revocation of this authorization will not affect any action that you have taken or information that you have already released, based upon the authorization, before you receive my request to revoke authorization.			
Privacy Officer NALC Health Benefit Plan 20547 Waverly Court Ashburn, VA 20149			
Section E — Signature / Authorization			
I,, have had full opportunity to read and consider the content of this form. I understand that by signing this form, I am confirming my authorization that the NALC Consumer Driven Health Plan may disclose my PHI to the person(s) named on this form, for the purpose described above.			
Signature Date			
(Signature must be the same as the name listed in Section B – Individual's Information)			
Please complete and sign this form, and return it to our Privacy Officer, at the address shown in Section D. A pre-addressed envelope is enclosed for your convenience. You are entitled to a copy of this completed form.			