High Option
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 E. 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 — Purpose

This form allows you (the "Individual") to give the NALC Health Benefit Plan permission (authorization) to disclose your protected health information (PHI) to a person that will act as your Authorized Representative. The information covered by this authorization is PHI, including identification of treating providers of care; diagnoses; procedures; 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 Health Benefit 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

I understand that the Plan will not disclose my PHI, except for the purpose of treatment, payment, and health care operations, or as required by law, without my written authorization. For this reason, **I authorize you to disclose my PHI to the person(s) named in Section C** for the purpose(s) set forth herein. I understand that the information disclosed pursuant to this authorization may no longer be protected by federal or applicable state privacy laws, and my Authorized Representative may further disclose my PHI without my authorization. I acknowledge that my authorization is voluntary.

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 only 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.

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I authorize the NALC Health Benefit Plan to release/disclose PHI as follows:

Authorized Representative #1

Full Name_____ Phone Number_____
(please print)

Relationship to You _____
(such as: spouse, parent, child, HBR, friend)

Release the following information about me (check all that apply):

___ Entire Claims Record ___ Claims Record from (specify dates)_____ to _____
___ The following claim record (specify dates) of services, name(s) of provider(s), diagnosis, other information

_____

For the purposes of (check all that apply):

___Further Medical Care
___Health Eligibility/Benefits
___Legal Investigation or Action
___At my request
___Personal
___Changing Providers
___Other (specify):

_____

I authorize the NALC Health Benefit Plan to release/disclose PHI as follows:

Authorized Representative #2

Full Name _____ Phone Number_____
(please print)

Relationship to You _____
(such as: spouse, parent, child, HBR, friend)

Release the following information about me (check all that apply):

___ Entire Claims Record ___ Claims Record from (specify dates)_____ to _____
___ The following claim record (specify dates) of services, name(s) of provider(s), diagnosis, other information

_____

For the purposes of (check all that apply):

___Further Medical Care
___Health Eligibility/Benefits
___Legal Investigation or Action
___At my request
___Personal
___Changing Providers
___Other (specify):

_____

Attach separate page to list additional Representatives

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 Health Benefit 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.