MUST BE COMPLETED FOR EACH PLAN YEAR.

"The Professional Approach to Insurance"

HIPAA Authorization Form for Section 125 Cafeteria Plan

We understand that you may wish us to communicate with others about your Cafeteria Plan accounts As you may be aware there is certain information regarding your health that is protected by state and federal laws. These laws have been put into place in order to help ensure your privacy. We therefore cannot use or disclose your protected information without your written authorization. We are very serious about protecting your personal information. We appreciate your cooperation and assistance in helping us comply with state and federal laws.

If you wish to grant a person or entity legal permission to access your protected information, please complete the below information. If all fields are not completed on this form, we will be unable to process the request and the form will be sent back to you.

Employer ____ Work Phone __________________________

Employee Name ____ Home Phone __________________________

SS # ____________________ Mailing Address ____

City ______________________________ State ______________ Zip Code ________________

I authorize Humphrey & Pace Benefit Planning, Inc., and its designated employees, to use and disclose any and all information pertaining to my Cafeteria Plan Accounts to:

____

____

____

Name and address of recipient(s)

EMPLOYEE AUTHORIZATION

- My protected information may include, but is not limited to: enrollment status, claim status, claim content and balance of account(s).
- I understand that I have the right to revoke this authorization in writing at any time. If I revoke my authorization, the information described above will no longer be used or disclosed. Any uses or disclosures already made with my permission cannot be taken back. I may revoke this authorization by sending a written statement to Humphrey & Pace Benefit Planning, Inc., 700 E. Main Street, Suite 107, Medford, OR 97504.
- This authorization does not approve the recipient(s) listed above to sign documents in regards to my account, including Request for Reimbursement Forms.
- **Unless revoked, this authorization will be in force and effect until the end of my current plan year.**

Employee Signature ____ Date ________________

700 East Main Street, Ste 107, Medford, OR 97504
Phone (541) 779-5881 Fax (541) 779-5511