

APPOINTMENT OF PRIVACY OFFICIAL

WHEREAS, pursuant to the Health Insurance Portability and Accountability Act of 1996, the Department of Health and Human Services ("HHS") has promulgated standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E (the "Privacy Rules");

WHEREAS, the Privacy Rules require that each covered entity (as defined in the Privacy Rules) is required to designate a privacy official who is responsible for the development and implementation of the policies and procedures that the covered entity is required to adopt pursuant to the Privacy Rules;

WHEREAS, (COMPANY NAME) EMPLOYEE BENEFIT PLAN (the "Plan") is a covered entity (as defined in the Privacy Rules);

NOW THEREFORE, the undersigned, being an authorized officer of (COMPANY NAME), which is the plan administrator and named fiduciary of the Plan, adopts this Appointment of Privacy Official on behalf of the Plan.

1. (Employee's name), is hereby appointed to serve as the Plan's privacy official, effective as of _____.
2. The Corporation, in its capacity as administrator and named fiduciary of the Plan, hereby delegates to the above-named privacy official (the "Privacy Official") authority and responsibility, to the fullest extent permitted by ERISA and other applicable law, to:
 - a. Determine the policies and procedures that are necessary or appropriate for the Plan under the Privacy Rules;
 - b. Develop and formally adopt on behalf of the Plan such policies and procedures;
 - c. Implement such policies and procedures with respect to the Plan's operations; and
 - d. Take such other steps and execute such documents on behalf of the Plan as may be necessary or appropriate to carry out the Privacy Official's responsibilities.

IN WITNESS WHEREOF, this Appointment of Privacy Official is executed this ____ day of _____, 2004.

Name

Position

AUTHORIZATION TO DISCUSS INSURANCE CLAIMS

You have asked an employee of (Company Name) (the "Company") to discuss one or more claim(s) for benefits that you filed under (Company Name) Benefit Plan (the "Plan") with (Carrier Name) (the "Carrier"). Under federal rules providing certain protections of the privacy of individuals' health information, the Carrier cannot disclose certain information regarding your claims to the Company without first receiving your written authorization. Therefore, before the Company can discuss your claim(s) with the Carrier, you will need to provide a written authorization for the Carrier to disclose information regarding your claims under the Plan to the Company. Completing and signing the following authorization will allow the Carrier to fully discuss your claim(s) with the Company. **If you would prefer that the Company not receive this information from the Carrier, you should not sign the authorization.** Please note that, if you are completing this form to allow use or disclosure of anyone's health information other than your own, including your child's health information, the pronouns "I" and "you" in the authorization below refer to that other individual. Authorization the use or disclosure of another individual's health information requires certification and demonstration of authority to act on behalf of that individual to give that authorization.

You do not have to provide this authorization in order to pursue an appeal of any denial of your claim(s). If you appeal, the Carrier will provide full and fair review of your appeal in accordance with the terms of the Plan, and you will not need to sign an authorization for that appeal to go forward.

HEALTH INFORMATION AUTHORIZATION

Please complete the following information to specify the use or disclosure of health information that you are authorizing. Federal rules providing certain protections of the privacy of individuals' health information may require your authorization before the Plan may use, receive or disclose health information.

Employee Name: _____ Social Security #: _____

Name of Claimant: _____

Authorization to Use or Disclose Health Information

I hereby authorize the use or disclosure of my health information as described in this Authorization.

Authorized Use or Disclosure

1. Specific description of the health information that I am authorizing to be used, disclosed or released (including dates to which the information pertains, if applicable):

Important Information About This Authorization and Your Rights:

- a) You may refuse to sign this Authorization. The Plan will not condition eligibility for, enrollment in, or payment of benefits under the Plan on provision of this Authorization.
- b) You may revoke this Authorization at any time by providing a written and signed statement.
- c) You may inspect or copy the health information described in Item 1 by requesting to do so.

If health information is disclosed pursuant to this Authorization it may no longer be protected under the terms of the federal rules providing certain protections of the privacy of individuals' health information, and that health information may be re-disclosed by the recipient. You may wish to obtain assurances from the person(s) or organization(s) specified in Item 3 above that they will not further disclose your health information that they receive pursuant to this Authorization.

- d) If the Plan is requesting this Authorization, you will be provided with a signed copy of it.

I hereby certify that I have read the provisions of this Authorization, and that I understand and agree to its terms. The use, disclosure or release of information is at my own request.

Signature of Individual
(Guardian in the case of a minor child)

Authorization Expiration Date

Date of Signature

Revocation of Authorization

EXAMPLE