North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

MEMBER AUTHORIZATION REQUEST FORM
ELIGIBILITY AND ENROLLMENT SUPPORT CENTER

You may give **Benefitfocus.com, Inc.**, the Eligibility and Enrollment Services vendor for the North Carolina State Health Plan for Teachers and State Employees, hereinafter referred to as "the Plan," written authorization to disclose your Protected Health Information (PHI) to anyone you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below. Completion of this form will not change the way that the Plan communicates with members.

MEMBER NAME	MEMBER DATE OF BIRTH *(month, day, year)*
LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER	MEMBER ADDRESS ON RECORD

At my request, I authorize the Plan and their business associates to disclose my PHI to ***(enter name and relationship of person/entity who will receive your PHI)***:

I authorize the Plan and their business associates to disclose the following PHI to the person/entity listed above:

- ☐ Any information requested
- ☐ Premium information
- ☐ Enrollment information
- ☐ Benefit information
- ☐ Request enrollment and personal data changes
- ☐ Other (please list specific PHI):_____

I would like this authorization to expire on:

☐☐ ☐☐ ☐☐☐☐ MONTH / DAY / YEAR

OR ☐ **When my coverage expires.**

(If no expiration date is provided, this authorization will expire twelve (12) months from the date of receipt by the Plan.)

I understand that I may revoke this authorization at any time by giving the Plan written notice mailed to the address at the bottom of this form. I also understand that revocation *will not* affect any action the Plan and their business associates took in reliance upon this authorization before receiving my written notice of revocation.

I also understand that the Plan *will not* condition the provision of health plan benefits on this authorization. I further understand that if the persons or entities I authorize to receive my PHI are not health plans, covered health care providers or health care clearinghouses subject to the Health Insurance Portability and Accountability Act (HIPAA) or other federal health information privacy laws, they may further disclose my PHI and it may no longer be protected by HIPAA or federal health information privacy laws. I also release and discharge the Plan, and their business associates, including Benefitfocus, from any and all liability, cost and claims of whatsoever kind and nature arising from the release of this information.

Signature_____Date _____

If signed by a personal representative:

Print your full name: _____

Describe your authority to act for the member (e.g., power of attorney, administrator, parent of minor child, executor of estate, etc.):

_____

NOTE: The Plan will consider the effective date of this authorization to be the date that Benefitfocus enters this authorization into its system, typically five days following receipt. If you would like this authorization to become effective on a date after Benefitfocus enters the authorization into its system, please insert the date here:

☐☐ ☐☐ ☐☐☐☐ MONTH / DAY / YEAR

RETURN THIS AUTHORIZATION TO:

Eligibility and Enrollment Support Center
250 Marquette Ave
Suite 900
Minneapolis, MN 55401

Email: AuthorizedRepresentative@Benefitplace.com

Please provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: (1) your name, (2) your member ID number, (3) your date of birth, (4) your address on record, and (5) the type of PHI you have authorized to be released.

North Carolina State Health Plan for Teachers and State Employees

INSTRUCTIONS FOR FILLING OUT THE AUTHORIZATION REQUEST FORM

SUBMITTING THIS AUTHORIZATION FORM IS OPTIONAL. You do not need to send it unless you want someone else to have access to your Protected Health Information (PHI) such as your spouse, a family member or friend. This is your choice. Submitting this authorization form will not affect your coverage.

ONLY ONE PERSON PER FORM. Only one person may give their authorization per form. Also, only one person may be authorized per form to receive PHI.

YOU MUST FILL IN THE FOLLOWING INFORMATION on the form; otherwise, the Plan cannot accept your authorization request.

1. Your Name must be filled in the "Member Name" blank.

2. Your Date of Birth must be filled in the "Member Date of Birth" blank.

3. Your last four digits of your Social Security Number must be filled in the "Social Security" blank.

4. Your Entire Address currently on record must be filled in the "Member Address on Record" blank.

5. Name of Person or Entity You are Authorizing to receive your PHI must be filled in the blank for "Name" which is immediately below the statement "At my request, I authorize the Plan and their business associates to disclose my PHI to..."

6. Relationship. The authorized person's or entity's relationship to you must be filled in the blank "Relationship to Member/Dependent."

7. The Type of PHI you are authorizing this person or entity to receive must be checked in the boxes provided, which are underneath the statement "I authorize the Plan and their business associates to disclose the following PHI..." If you check the box for "Any information requested," this means that the person you are authorizing may receive any of your PHI that they request.

8. When This Authorization Expires should be filled in the blank after the statement "I would like this authorization to expire on:" Or, you may check the box "when my coverage expires."

9. Your Signature. You must sign your own authorization form unless you are the legal personal representative *(see below)* or the parent of a minor child who is giving the authorization.

10. Date. The date you signed the authorization form must be filled in the blank next to your signature.

PERSONAL REPRESENTATIVES. A personal representative is a person who has legal authority to make decisions for the member. If a personal representative is signing for the member, the personal representative must state their authority to sign in the blank spaces below the signature line. If the personal representative is not a parent, then the document(s) giving the personal representative legal authority to sign must be on file with Benefitfocus, for the Plan to accept the request ***(if already submitted and valid, you do not need to submit new forms)***.