Employee Benefits Corporation

Participant Authorization Form

Fax to: **608 831 4790**
Mail to: **Employee Benefits Corporation**, PO Box 44347, Madison WI 53744-4347
Phone support: **800 346 2126** | 608 831 8445
E-mail support: **participantservices@ebcflex.com**

Account Holder Information

Last 4 Digits of Social Security or Identification Number (Required)

Last Name

First Name

E-mail Address (we do not share your e-mail address)

Company Name

PHI Authorization

I _____ (name) am a participant in a plan sponsored by my employer. I understand that my employer has engaged Employee Benefits Corporation to provide administrative services to the plan. I hereby authorize Employee Benefits Corporation to use or disclose, with the person(s) listed below, my protected health information (PHI) regarding claims submission and reimbursement, eligibility for the plan, enrollment and disenrollment, or other information related to the plan(s) checked below.

Plan type(s) for which PHI may be released (check all that apply):

☐ BESTflex℠ Plan ☐ EBC HRA℠

Person(s) authorized to receive PHI and their relationship:

PHI User Name

Relationship to Participant (spouse, son, daughter)

PHI User Name

Relationship to Participant (spouse, son, daughter)

PHI Authorization Expiration

○ Authorization will expire when I am no longer a participant in the plan or my employer terminates the plan

○ From: Date (mm-dd-yyyy) To: Date (mm-dd-yyyy)

○ On: Date (mm-dd-yyyy)

PHI Type Authorized

○ Any information related to the plan(s)

○ Only:

Specify the type of information that may be disclosed

Account Holder Certification

I may revoke this authorization at any time prior to its expiration date by notifying Employee Benefits Corporation in writing, but revocation will not affect any actions Employee Benefits Corporation took before the revocation was received. I may see and copy the information requested on this form if I ask for it. I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment). The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving person. Employee Benefits Corporation is not responsible for what the receiving person does with the information.

_____

Account Holder Signature

Date (mm-dd-yyyy)

