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**

Participant 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

Information may be released relating to the following plan(s) or service(s) – (Check all that apply):

☐ BESTflex℠ Plan ☐ EBC HRA℠ ☐ COBRASecure ☐ Billing Services

Type of Information Authorized for Release

○ Any information related to the plan(s) and service(s) identified above. This could include information about claims submission and reimbursement, eligibility for the plan, enrollment and disenrollment, premium and billing information, or other information, including information that is protected health information (PHI).

○ Only:

Specify the type of information that may be disclosed

Person or Entity Authorized to Receive This Information

Last Name | First Name | MI | Relationship to Participant (spouse, son, daughter)

Or

Entity Name | Phone | Purpose of Disclosure

Address | City | State | Zip

Effective Dates of Authorization

Authorization is **effective** on:

Date (mm-dd-yyyy)

Authorization **expires** (choose one):

○ When I am no longer a participant or receiving the services indicated, or my employer terminates its relationship with Employee Benefits Corporation

○ On:

Date (mm-dd-yyyy)

Authorization and Certification

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. I hereby authorize Employee Benefits Corporation to use or disclose to the person(s) or entity listed above, my personal information and/or protected health information (PHI) as described in this document.

I understand that 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 any 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.

_____
Participant Signature

Date (mm-dd-yyyy)

_____
Parent/Legal Guardian/Agent Signature if Participant is a minor or incapacitated

Date (mm-dd-yyyy)

_____
Parent/Legal Guardian/Agent Name (Last, First, Middle Initial)

Relationship to Participant

