

# Participant Authorization Form

Phone support: **(800) 346-2126** | (608) 831-8445  
Email: **participantservices@ebcflex.com**

## Participant Information

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

Last Name

First Name

Email Address (we do not share your email address)

Company Name

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

Flexible Spending Account       Health Reimbursement Arrangement       Commuter Benefits       Lifestyle Spending Account  
 COBRA       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.

**X**

Participant Signature

Date (mm-dd-yyyy)

**X**

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

Date (mm-dd-yyyy)

**X**

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

Relationship to Participant