Discovery Benefits®
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Authorized Representative Form — HIPAA

This form is to document the designation of one or more authorized representative(s) for a participant. This form authorizes the release of medical and/or COBRA information to the named representative(s). This authorization does not provide your authorized representative(s) with any authority, either implied or direct, over any direct care decisions or account management access, including online account login information. If you wish to set up a power of attorney or living will, please discuss this with your attorney. We will not condition benefit payments, enrollment or eligibility for benefits on the execution of this form.

*=Required Fields

Step 1: Participant Information

*Employer Name or Employer Sponsoring Benefits (Do not abbreviate)

Employee ID (Flex only)

*Participant Name (First, MI, Last)

*Social Security Number

Step 2: Authorized Representative Information

Please fill in the requested information below for the individual(s) that you wish to add or remove as an authorized representative. Please also check the box below each person's name to add or remove your authorization for that individual. Please note, authorization will be added for the individual(s) listed below if you do not select an option to add or remove the authorization.

*Authorized Representative Name

Day Telephone

Add Authorization ☐ Remove Authorization ☐

*Authorized Representative Name

Day Telephone

Add Authorization ☐ Remove Authorization ☐

Step 3: Expiration & Revocation and Authorized Use & Disclosure

I understand that, due to HIPAA regulations, Discovery Benefits will not disclose my personal health information to other parties without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named above for the purpose of assisting with, or facilitating, the coordination or payment of my health benefits. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my authorized representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

I understand I have the right to revoke or end this authorization at any time. I understand that if I do not wish the person(s) named in Step 2 to remain my authorized representative(s), I must revoke this authorization by giving written notice of my decision to Discovery Benefits, Inc. I understand that my revocation of this authorization will not affect any action that you have taken or any information that you have already released based upon this authorization before you actually receive my request to revoke it.

*Signature

*Date

*Signer Identification (please select one)

☐ Self ☐ Parent of Minor ☐ Guardian ☐ Other Authorized Representative (please explain):

Note: Proof of legal authorization may be required.

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