HealthPlans
A HARVARD PILGRIM COMPANY

ONLINE ENROLLMENT ACCESS FORM

PLAN SPONSOR AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Group Number: ___ ___ ___ ___ ___ ___

Group Health Plan Name: _____

Health Plans, Inc. requires authorization from Plan Sponsors in order to provide employees and other workforce members under the control of the Plan Sponsor, and Business Associates of the Plan Sponsor, access to online enrollment information. This procedure is required as in accordance with the Health Insurance Portability and Accountability Act (HIPAA), which was enacted to protect the privacy of individuals' health information.

Only approved classes of employees or other workforce members as set forth in the HIPAA Privacy Provisions section of your Group Health Plan's Summary Plan Description, or authorized Business Associates, may be given access to an individual's protected health information. By completing and signing this form, you are verifying that you are on this list and that you have authorized the designated employees and/or Business Associates listed on the following page to have access to online enrollment information in order to perform necessary administrative functions for the management and operation of your Plan. In addition, you agree that you have provided such employees with the HIPAA training necessary, and/or that you have entered into a validly existing Business Associates Agreement with any designated Business Associate, to ensure that they will use or disclose an individual's protected health information ONLY for the purposes set forth in the HIPAA Privacy Provisions section of your Plan's Summary Plan Description, including but not limited to the following:

- The designated employees and Business Associates will only use or disclose an individual's protected health information for Plan administrative purposes, as required by law, or as permitted under the HIPAA regulations;
- The designated employees and Business Associates will NOT use or disclose an individual's protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the Plan Sponsor unless permitted under HIPAA;
- The designated employees and Business Associates will take appropriate and reasonable safeguards to protect the confidentiality, integrity and availability of the information they create, receive, maintain, or transmit; *and*
- The designated employees and Business Associates will promptly report to the Plan Sponsor any use or disclosure of an individual's protected health information that is made in violation of or is inconsistent with the rules set forth in the Plan's Summary Plan Description.

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I would like the following employee(s) to have access to the Plan's online enrollment information:

1. Employee Name: _____ Title: _____
   Email Address: _____ ❑ View Only ❑ Edit Authority

2. Employee Name: _____ Title: _____
   Email Address: _____ ❑ View Only ❑ Edit Authority

3. Employee Name: _____ Title: _____
   Email Address: _____ ❑ View Only ❑ Edit Authority

4. Employee Name: _____ Title: _____
   Email Address: _____ ❑ View Only ❑ Edit Authority

I would like the following Business Associate(s) to have View-Only access to the Plan's online enrollment information:

1. Business Associate Name: _____ Company: _____
   Email Address: _____ Title: _____

2. Business Associate Name: _____ Company: _____
   Email Address: _____ Title: _____

3. Business Associate Name: _____ Company: _____
   Email Address: _____ Title: _____

4. Business Associate Name: _____ Company: _____
   Email Address: _____ Title: _____

Health Plans will send a temporary password to each employee and/or Business Associate listed above via secure email in order to set up online access. The subject line of this email will be ***PGP Universal Secured Message***. Only ***ONE*** user per password is allowed. Once the employee/Business Associate has received a temporary password, he or she should contact your Health Plans Account Manager if further help accessing online enrollment information is needed.

Authorized Plan Representative Signature: _____

Print Name: _____

Title: _____ Date: _____