PREMERA BLUE CROSS

THE NELSON TRUST

Benefit and Claim Information Authorization Release

Purpose

The attached form is to:

SECTION 1: Authorize an individual of your choice to discuss your benefit(s) or claim(s), including sensitive claim information; and/or

SECTION 2: Authorize your parent or spouse/domestic partner to view your sensitive claim(s) and online account profile information. *(Only applies to enrolled family members.)*

SECTION 3: Authorize the Company as noted in SECTION 1 and 2 by signing this form.

By completing this form, you authorize us to share the information with the person or entity you name. We would not normally give this information to this person or entity.

Instructions

Did you know? For immediate authorization, you can complete these authorizations in your online account.

1. Please complete SECTIONS 1-3 of this form
2. Fax this completed form to 425-918-5592
3. If you choose to mail this form instead of faxing, the address is:

   Premera Blue Cross
   P.O. Box 91102
   Seattle, WA 98111-9202

4. Please keep a copy of this request for your records.

For more information on how we disclose your information, see the Notice of Privacy Practices on **premera.com** or call Customer Service at 800-809-9250.

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PREMERA BLUE CROSS

Member Name: _____ Date of Birth: _____
(First/MI/Last)

Identification (ID) Number: _____

AUTHORIZED INDIVIDUAL INFORMATION:

I authorize the following individual to receive my personal health/claim information as indicated below:

Is this individual covered under your plan? ☐ Yes ☐ No

Authorized Individual's Name: _____ Phone: ( ) -

Address: _____ Fax: ( ) -

City: _____ State: _____ ZIP: _____

INFORMATION TO BE RELEASED: I allow Premera Blue Cross or any of its affiliates (the "Company"), to share the member's personal information with the person/entity listed, above. I understand that the Company needs my written or online authorization to release any sensitive information. Sensitive information includes testing, diagnosis, procedures and/or treatment for Alcohol and/or Chemical Dependency, Reproductive Health, Sexually Transmitted Diseases (including HIV/AIDS), Genetic Information or Psychiatric Disorders/Mental Illness.

SECTION 1: Authorization to discuss your benefit(s) or claim(s), including sensitive claim information

This section of this form is to authorize an individual of your choice to:

☐ Discuss benefit(s) or claim(s), including sensitive claim information. **Complete check boxes as applicable below and then continue to SECTION 2.**

☐ No authorization to discuss benefit(s) or claim(s), including sensitive claim information. **Skip to SECTION 2.**

I allow the Company to share information related to the box(es) I have checked below:

☐ General Health Care (claims, billing, and eligibility information not related to one of the sensitive categories below)

☐ Alcohol and/or Chemical Dependency

☐ Reproductive Health (including abortion)

☐ Genetic Information (genetic information is not collected or used for underwriting or enrollment purposes)

☐ Sexually Transmitted Diseases (HIV/AIDS)

☐ Psychiatric Disorders/Mental Illness

☐ Other: _____

PURPOSE FOR RELEASE:

☐ At the request of the Individual

☐ At the request of the Company for:
- ☐ Research
- ☐ Other: _____

☐ Other (please state specific date, specific time period, event or condition):

I understand that if the member prefers not to allow sharing of any type of personal information shown, above, Premera will not share the information. **This authorization will last until the expiration date, which is no more than 24 months from the signature date, or until you cancel it or are no longer covered by this plan**.

Benefit and Claim Information Authorization Release

SECTION 2: Authorization to view your sensitive claim(s) and online account profile information

☐ Allow parent or spouse/domestic partner to view sensitive claim(s) (Genetic Information, Chemical Dependency, Mental Health, STD or Reproductive Health) and online account profile information (Benefit Summary including Usage and Limits, Spending Activity Report, etc.). *(Only applicable if the authorized representative is enrolled on the plan.)* **Continue to SECTION 3.**

☐ No authorization to view sensitive claim(s) online. **Continue to SECTION 3.**

SECTION 3: Authorization and Signature

CANCELLING THIS RELEASE: I may change my mind and cancel these authorizations at any time within my online account or via this form. After the Company gets my notice, the Company will cancel this release within five (5) business days. I understand that the Company may already have shared some or all of my information and that the Company will not be liable for any information already released.

DURATION OF RELEASE: Except as stated in SECTION 1, these authorization(s) apply only to services obtained while the member is covered by this Premera administered plan and remain in place until cancelled.

ADDITIONAL SHARING: The person or entity that receives the member's **i**nformation may be able to share it. State and federal privacy rules may no longer protect it.

NO CONDITION: This release is voluntary. It does not affect the member's enrollment in a health plan, eligibility for benefits, or payment of claims.

WHO MUST SIGN THIS FORM*:

- For a member age 12 or younger: the parent or legal guardian
- For a member age 13 to 17, if the "general health care" box is checked in SECTION 1: the parent or legal guardian.
- For a member age 13 to 17, if any other box is checked in SECTION 1or 2: the member (unless a court with jurisdiction has deemed the member incapable of consenting to his or her own services and has appointed a legal guardian)
- For a member age 18 or older: the member (unless a court with jurisdiction has deemed the member incapable of consenting to his or her own services and has appointed a legal guardian)

Sign your name: _____ Date signed: _____

Print your name: _____

*If not the member, I am the ☐ Parent ☐ Legal Guardian ☐ Holder of Power of Attorney/Legal Representative
If you are the legal guardian or holder of a power of attorney/legal representative for the member, please attach legal documentation.

When completed, fax this form to:
Fax: 425-918-5592
Or mail to: Premera Blue Cross, P.O. Box 91102, Seattle, WA 98111-9202