LifeWise Assurance Company

# 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, 2 and 3 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:

   LifeWise Assurance Company
   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 **student.lifewiseac.com** or call Customer Service at 800-971-1491.

# Benefit and Claim Information Authorization Release

LifeWise Assurance Company

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 LifeWise Assurance Company 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, LifeWise 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

LifeWise Assurance Company

## 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 4.**

☐ No authorization to view sensitive claim(s) online. **Continue to SECTION 4.**

## 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 LifeWise Assurance Company 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 1, 2 or 3: 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:** LifeWise Assurance Company, P.O. Box 91102, Seattle, WA 98111-9202

LifeWise
Assurance Company

**Discrimination is Against the Law**

LifeWise Assurance Company (LifeWise) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. LifeWise does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. LifeWise provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). LifeWise provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that LifeWise has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-6396, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@LifeWiseHealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

**Language Assistance**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-971-1491 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-971-1491（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-971-1491 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-971-1491 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-971-1491 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-971-1491 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-971-1491 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-971-1491 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-971-1491（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-971-1491 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-971-1491 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-971-1491 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-971-1491 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-971-1491 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-971-1491 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-971-1491 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-971-1491 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-971-1491 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-971-1491 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-971-1491 (TTY: 711).

**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-971-1491 (TTY: 711) تماس بگیرید.

037404 (11-06-2019)