Authorization to Release Personal Information

KEEP A COPY OF THIS COMPLETED FORM FOR YOUR PERSONAL RECORDS

SUBMIT THIS DOCUMENT BY:
EMAIL: ParticipantServices@BenefitResource.com
FAX: (877) 918-3622
MAIL: Benefit Resource, LLC | PO BOX 642 | Willow Grove, PA 19090

YOU SHOULD READ THIS CAREFULLY. When you complete and sign this form, you give Benefit Resource, LLC. an Inspira Financial Solution (BRI) permission to release your personal information to another person or organization*. You'll name the Authorized Representative below. Your personal information pertains to your account at BRI. It may include, but is not limited to: Claim information (provider name; if you need to substantiate a claim; amount; etc.); reimbursements that the account has paid; explanation of payment (EOP); receipt request letters; premiums that you pay; insurance carrier name; web access status; debit card status; bank account information; and general plan inquiries.

- The federal privacy standards that protect your personal information may not apply to your Authorized Representative. This means your Authorized Representative may be able to give your information to others.
- This authorization ends twelve months after the date your benefit eligibility terminates, as reported by your Plan. But you can end this authorization earlier. You can use this form to notify us in writing. This is important because we can't cancel an authorization over the phone. If you do cancel early, it won't affect any actions taken before we receive your written request.
- This request is voluntary. It has no impact on your eligibility for benefits; treatment you receive; your enrollment; or claim payments. Your plan can't ask you to sign this form for any reason.
- *Don't use this form to allow your providers to file billing, claim or Explanation of Benefits (EOB) information or documentation. They don't need your signed authorization to submit that information to BRI.

Instructions

1. To authorize the release of personal information, complete sections A, B, C and E of this form. Return it to BRI.
2. To revoke or cancel an authorization, complete sections A, B and D of this form. Return it to BRI.
Note: We can't process this form if it isn't completed and signed. We may also need additional documentation to process this form.

Section A – Member Information *(This is the person whose information will be released.)*

AUTHORIZED REPRESENTATIVE WILL NEED TO HAVE ALL OF THIS INFORMATION WHEN CONTACTING BRI

Member Name *(First, MI, Last)*

State of MN Employee ID Number **OR** **Social Security Number** *(Last four digits only)*
XXX - XX -

Address

City

State

Zip Code

Employer Name *(Previous employer if COBRA or Retiree Account)*
State of Minnesota

Daytime Telephone
( ) -

Section B – Authorized Representative Information *(This is the person or organization that you authorize to receive Member information.)*

MEMBER MUST COMPLETE A SEPARATE FORM FOR EACH AUTHORIZED REPRESENTATIVE.

Authorized Representative or Organization Name

In most cases, no additional documents must be submitted with this form. Just be sure the Member signs it. This is needed in order for the authorization to become effective. There are two situations where additional documents are needed:

1. **If the Member is deceased:** You must send BRI executorship or similar documentation and the death certificate. BRI can't discuss the deceased member's account with anyone without this documentation. BRI can't rely on a Durable Power of Attorney, Advance Directive, Guardianship or Conservatorship papers after the death of the Member. Those powers are no longer valid.
2. **If the Member is incapacitated:** If the member's Legal Representative signed this form, then they must send BRI documentation that verifies the Legal Representative's status. Legal documentation includes a Durable Power of Attorney, Guardianship or Conservatorship papers.

Section C – Information To Be Released To Authorized Representative *(Select only one.)*

☐ **Grant Full Account Access:** This gives the Authorized Representative the same access as the Member. It allows the Authorized Representative to receive all account information; submit claims and required documents; and make changes to the account. This includes resetting web login and password; requesting debit cards and changing account information.

☐ **Grant Limited Account Access:** This is for information available by phone only. It won't allow the Authorized Representative to make or authorize account changes. And it won't allow the Authorized Representative to request or receive any member specific account documents.

Section D – Revocation / Cancellation Request *(This is the person or organization that you no longer authorize to receive Member information.)*

Complete only when requesting BRI to revoke or cancel an authorization request. You must complete Sections A, B and D.
Until BRI receives and processes your request to cancel, the Authorized Representative still has the access that you previously granted.

I wish to revoke/cancel account access for (Authorized Representative Name)

Member Name

Signature

Date *(MM/DD/YYYY)*

Section E – Member Signature or Legal Representative's Signature

I request and authorize BRI to release my information to the Authorized Representative named above. I understand that this may include protected health information (PHI). I understand that this authorization expires at the end of the twelve-month period following the end of my coverage. I also understand that this authorization will be in place until then, unless I send a written request to cancel it. I understand this request is voluntary for me. The plan cannot base my eligibility for benefits, treatment, enrollment or claims payment on this authorization. I also understand that once information is disclosed to the Authorized Representative, the federal privacy standards protecting my health information may not apply to the Authorized Representative. I understand that this means that the Authorized Representative may be able to share this information.

Print Name

Signature *(If member signs, no additional documents are needed.)*

Date *(MM/DD/YYYY)*

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Minnesota Management and Budget
NOTICE OF COLLECTION OF PRIVATE DATA

Minnesota Management and Budget administers the State Employee Group Insurance Program (SEGIP). This notice explains why we may request information (data) about you, your dependents and beneficiaries, how we will use it, who will see it, and your obligation to provide that information.

WHAT INFORMATION WILL WE USE?
We will use the information you provide us at this time, as well as information you have previously provided us about yourself, your dependent(s), and/or your beneficiary. If you provide any information about yourself or your dependent or beneficiary that is not necessary, we will not use it for any purpose.

SEMA4, the information system used to administer employee benefits, contains required information fields that may not be necessary for us to process your request. We do not need the gender or marital status for your beneficiary designation, so you may enter "unknown" in these fields. We only need your dependent's date of death to process a death benefit claim or to discontinue the dependent's coverage due to his or her death. Student status and disability status are needed only to determine eligibility for insurance continuation for your dependent. We only need your dependent's social security number to offer insurance continuation or process a death benefit.

WHY WE ASK YOU FOR THIS INFORMATION?
We ask for this information to process your request to add or change coverage for yourself, your dependent or a beneficiary. The requested information helps us to determine eligibility, to identify you and your dependents and beneficiaries, and to contact you or your dependents and beneficiaries. We use the information so that we can successfully administer SEGIP, including analyzing unidentifiable aggregate data to develop new programs and ensure current programs are effectively and efficiently meeting member needs. We may ask for information about you that we have already collected, including all or part of your social security number, in order to ensure we are matching you to the correct change request or other insurance benefit transaction.

DO YOU HAVE TO ANSWER THE QUESTIONS WE ASK?
You are not legally required to provide any of the information requested.

WHAT WILL HAPPEN IF YOU DO NOT ANSWER THE QUESTIONS WE ASK?
If you do not answer these questions, the insurance benefit transaction you requested for you or your dependent or other insurance benefit transaction may be delayed or denied.

WHO ELSE MAY SEE THIS INFORMATION ABOUT YOU AND YOUR DEPENDENTS AND BENEFICIARIES?
We may give information about you and your dependents and beneficiaries to the insurance carrier you have chosen, SEGIP's representatives, vendors, and actuary, the Legislative Auditor, the Department of Health, any law enforcement agency or other agency with the legal authority to the information, and anyone authorized by a court order. In addition, the parents of a minor may see information on the minor unless there is a law, court order, or other legally binding instrument that blocks the parent from that information. We can use or relates this information only as stated in this notice unless you give your written consent to authorize release of the information to another person/entity, or if Congress or the Minnesota Legislature passes a law allowing or requiring us to release the information or to use it for another purpose.

Minnesota Management and Budget
NOTICE OF COLLECTION OF PRIVATE DATA

We ask for this information to process your request to add or change coverage for yourself, your dependent or beneficiary. The requested information helps us to determine eligibility, identify you and your dependents and beneficiaries, and contact you or your dependents and beneficiaries. We use the information so that we can successfully administer SEGIP, including using unidentifiable, aggregate data to develop new programs and ensure current programs effectively and efficiently meet member needs. We can use or release this information only as stated in this notice unless you give us your written permission to release the information or to use it for another purpose.

You are not legally required to provide us any of this information and you may refuse to provide the information. However, if you do not provide us the requested information, the insurance transaction you requested for you or your dependent or other insurance benefit transaction may be delayed or denied.

We may give information about you and your dependents and beneficiaries to the insurance carrier you have chosen, SEGIP's representatives, vendors, and actuary, the Legislative Auditor, the Department of Health, any law enforcement agency or other agency with the legal authority to the information, and anyone authorized by a court order. In addition, the parents of a minor may see information on the minor unless there is a law, court order, or other legally binding instrument that blocks the parent from that information. This information may also be used or released if Congress or the Minnesota Legislature passes a law allowing or requiring us to release the information or to use it for another purpose.

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