

Participant Consent Form

I consent to the use of and disclosure of my Protected Health Information for the purpose or healthcare treatment, claims payment and/or healthcare operations. I understand that I may revoke this consent and will submit a written request if I decide to do so. By signing this consent form I also agree that I have received a copy of the NECA Local No. 145 IBEW Welfare Plan Privacy Policies.

Participant Name (please print)

Participant Social Security Number

Participant Signature

Date

**** FAILURE TO SIGN THIS CONSENT FORM PERMITS THE PLAN TO REFUSE YOUR ENROLLMENT AND/OR DENY HEALTH CLAIMS.**

Authorization to Release Information

Effective April 14, 2003, the Fund Office is prohibited from exchanging information with anyone other than the individual (if they are 18 years of age or older) the information pertains or a Covered Entity (i.e. physician, hospital, claims payor). **If there is an individual or individuals, other than yourself, that you would like to grant access to your account (i.e. parents) please complete the section below.** You may revoke this access at any time by submitting a written request to the Fund Office.

THIS AUTHORIZATION IS FOR: (Please check one)

- 1. Enrollment/eligibility information only
- 2. All information, including medical

Please list the individual or individuals, **other than yourself,** on the following lines. If you need additional space please use the back of this form.

Name (Not Yourself)

Relationship

Name (Not Yourself)

Relationship

Name (Not Yourself)

Relationship

Participant Signature

Date

Pin Number

To access your information you must have a pin number. Please fill in the section below with a four-digit numerical pin number. If you lose or forget this pin number you must contact the Fund Office. We will send a new request for pin number that must be completed and returned before you can access your account.

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RETURN THIS FORM IMMEDIATELY TO THE FUND OFFICE