Protected Health Information Authorization for Customer Service Inquiries

Please complete this entire form and return to:

Truli for Health
Access Authorization Unit
P.O. Box 45014
Jacksonville, FL 32232

PURPOSE

I am the member listed in Section I.

This authorization is at my request to permit Truli for Health to respond to customer service inquiries regarding my Protected Health Information regarding health, dental and long-term care products.

SECTION I

Please provide the following information regarding the person whose Protected Health Information is to be released.

Member Name: ____

Member Number: ____

Group Number: ______________ Date of Birth: ________________

SECTION II

I authorize Truli for Health to release, orally and/or in writing, the following Protected Health Information concerning me:

- Identifying information (e.g., name, address, age, gender);
- Health care coverage information (i.e., general & plan-specific benefit information);
- Past, present and future claims information (except for any period of time during which a Confidential Communication address[1] was in effect); and
- Coordination of Benefit Information.

SECTION III

Please identify the person(s) to whom the member's Protected Health Information may be released and their relationship, i.e., sales agent, employer health benefit representative, parent, family member, friend, corporation, organization, law firm, vendor.

My information may be given to the person(s) listed below.

Please Print:

Name: ________________________ Relationship to Member: _____________________

Name: ________________________ Relationship to Member: _____________________

Name: ________________________ Relationship to Member: _____________________

SECTION IV

By law, this authorization must indicate that persons other than Truli for Health receiving member's Protected Health Information may not have to obey federal health information privacy laws and member's Protected Health Information may be further released by those persons.

This authorization is voluntary and is not a condition of enrollment in a health plan, eligibility for benefits or payment of claims.

SECTION V

This authorization will expire:

___________ / __________ / __________
Month Day Year

OR

____
The date member's Truli for Health coverage ends

It is advised that you place a specific expiration date on this authorization if you are designating a sales agent or employer as an authorized representative, or any other person for whom you may have designated to assist you with a specific, short-term task.

SECTION VI

Copy of Authorization
Please keep a copy of your signed authorization. A photocopy is as valid as the original.

SECTION VII

Right to Withdraw Authorization
I understand that I may withdraw this authorization at any time by giving written notice to the address listed on page 1 of this form. I further understand that withdrawal of this authorization will not affect any action taken by Truli for Health in reliance on this authorization prior to receiving my written notice of withdrawal.

SECTION VIII

Signature

Member Signature:____ Date: ______________

If a legal representative signs this authorization form on behalf of the member, please complete the following information:

Legal Representative's Name[2]: _______________________________ Date:______________

Relationship to the member: _________________________________

[1]A Confidential Communication address is one specified by an adult (age 18 or older) that is different than the address where the subscriber receives his or her mail.

[2]Please provide written documentation to support your status as a guardian or other legal representative.

Health coverage is offered by Truli for Health, an affiliate of Florida Blue. These companies are independent licensees of the Blue Cross and Blue Shield Association.