Flex Administrators, Inc.
FLEXIBLE BENEFIT PLANS
QUALIFIED PLANS • COBRA

Authorization for Release of Protected Health Information

For your FSA, HRA, MRA and/or HSA plan through

Employer Name: _____ (hereinafter referred to as the "Employer")

I. Information About the Use or Disclosure

Individual's name:_____

This authorization relates to the health plan(s) of Employer (hereinafter referred to as the "Plan"). I authorize the use or disclosure of my individually identifiable health information by or to any family member or member of my household, health care provider, the Plan sponsor, the insurer/TPA of the Plan, or any other entity providing services in connection with the Plan in order to process my enrollment in the Plan or to process any claim for my Plan benefits. This authorization is effective until the date I terminate enrollment in the Plan.

II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the Plan in writing, but the revocation will not have any affect on any actions the Plan took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity.

III. Signature of Individual or Individual's Representative

_____ _____

Signature of Individual or Individual's Representative
(Form MUST be completed before signing.)

Date

Printed name of the Individual or Individual's personal representative: _____

Relationship to the individual, including authority for status as representative: _____

Please Return Completed form to Flex Administrators, Inc.
Fax: 616-454-6090 | Email: Service@flexadministrators.com | Mail: 3980 Chicago Drive, Suite 230, Grandville, MI 49418