The Federal Employees Dental and Vision Insurance Program (FEDVIP)

Authorization for Disclosure of Information

BENEFEDS™

P.O. Box 797 | Greenland, NH 03840-0797 | 1-877-888-FEDS (1-877-888-3337) TTY 1-877-889-5680

Personal information

First name | M.I. | Last name

Address 1

Address 2

City | State/Territory

Country | Zip/Foreign postal code

Date of birth ___ / ___ / ___
Month / Day / Year

BENEFEDS User ID (optional)

I, the insured named above, authorize Long Term Care Partners, LLC (LTCP), the company that handles enrollment and premium administration for the Federal Employees Dental and Vision Insurance Program (FEDVIP) via BENEFEDS, to disclose information about my enrollment under the FEDVIP, including demographic information, billing and payment information, and other information related to the FEDVIP, to the individual(s) listed below. This will allow such individual(s) to assist me in matters related to my enrollment under the FEDVIP.

Name | Relationship | Telephone number

Name | Relationship | Telephone number

I understand that this authorization is voluntary. I understand this authorization will be valid until the earlier of: such time as I am no longer enrolled in a plan under the FEDVIP (at which time it will expire) or such time as this authorization is revoked by me. I understand that I may revoke this authorization at any time by notifying the BENEFEDS department at LTCP in writing at: **BENEFEDS Attn: HIPAA Privacy Office, P.O. Box 797, Greenland, NH 03840-0797**. Revoking this authorization will have no effect on any information released in reliance on this authorization before BENEFEDS received the revocation. I further understand that BENEFEDS will not condition enrollment on whether I sign this authorization. I understand that the individual(s) listed above may redisclose any information received. Once information is disclosed to the individual(s), I understand that the information may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) regulations and other applicable privacy laws.

Signature of the insured or insured's legal representative

(Required)

Date signed ___ / ___ / ___
(Required: mm/dd/yyyy)

If signed by a legal representative, printed name of representative

(Required)

If signed by a representative of the insured, please describe the authority under which the representative is authorized to act and enclose any related documentation (e.g., copy of power of attorney for disclosures of premium information or health care power of attorney for disclosure of other enrollment information):

Mail to: BENEFEDS, Attn: HIPAA Privacy Office | P.O. Box 797 | Greenland, NH 03840-0797 **Fax to:** 1-603-433-3811