INSURANCE TRUST
for Delta Retirees

AUTHORIZATION FORM
Plan Use and Disclosure of Protected Information

Member Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Phone Number: (____)** _____

Please read the entire form, complete Sections 1, 2, 3 & 4. Sign and date the form and return it to the Trust Retiree Service Center.

I, _____, Social Security Number_____ authorize to collect, use, and disclose information for:

List Plan Information	**Certificate Number (can be found on your billing statement, coverage confirmation or you can call the Retiree Service Center to receive)**
Insurance Trust for Delta Retirees	30999-__ __ __ __ __ __ __

Relating to my physical or mental health that could be used to identify me (called "Protected Information") as described below. I understand this authorization is voluntary and that if an organization or person(s) authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. Further, I understand this authorization is valid until I terminate my coverage in the Plan.

Protected Information is any information that relates to:

* my past, present or future physical or mental health condition;
* health care I have received or will receive; and
* payment for health care I have received or will receive.

1. I authorize the Plan to collect, use or disclose the following Protected Information: {please check 1 option below}

❑ All medical information pertaining to me.

❑ Only information about: _____
Please list the specific medical condition(s)

2. I authorize the following persons or classes of persons to use and disclose the Protected Information listed above in subsection 1 to the following people: {Please select 1 option.}

❑ All Authorized Employees of above listed health plans**,** such as Customer Service Representatives, Claims Representatives, Underwriters, etc.

❑ Only the following person(s) or class of persons. _____

(Please see other side)

3. **I authorize the following person(s) to act as my Authorized Representative(s) as indicated below.** {Please complete all that apply.}

   Person: _____ Relationship: _____

   Address: _____

   City:_____ State: _____ Zip: _____ Phone Number: (_____)_____
   This person may:

   ___ Receive my Protected Information

   Person: _____ Relationship: _____

   Address: _____

   City: _____ State: _____ Zip: _____ Phone Number: (_____) _____

   This person may:

   ___ Receive my Protected Information

4. **By checking this box [_] I acknowledge that my Protected Information shall be used or disclosed at my request. Further, this is not a condition of treatment, payment, enrollment or eligibility for benefits.** {Please be sure to check the box to validate your Authorization.}

5. **As the Privacy Notice previously received states, I understand that I have the right to revoke this Authorization in writing, except to the extent the Plan has taken action in reliance upon this Authorization.**

By my signature below, I acknowledge that I have read, understood and agreed to the terms of this Authorization.

X_____ **X**_____

Signature* Date

*If a personal representative signs this Authorization, please attach the appropriate legal documents that confirm this appointment.

Please return the signed form to:
Insurance Trust for Delta Retirees Service Center
P.O. Box 14464
Des Moines, IA 50306-3464
Or via Fax to: 515-365-1520
Or Scan and E-mail to: thetrust.service@mercer.com

If you have questions about this form or need assistance in completing it, please call the Insurance Trust for Delta Retirees Service Center Monday through Friday 7:30 am to 8:00 pm at 1-877-325-7265, option 1