Employer Group Vendor Designation Form

Harvard Pilgrim Health Care

Purpose – This form authorizes Harvard Pilgrim Health Care, Inc. and its affiliates (collectively, "Harvard Pilgrim") to disclose an employer group's information, including member protected health information, to a vendor (e.g., broker or other third party working on the employer group's behalf). Harvard Pilgrim will not release any information to the vendor until this form is completed.

All fields are required. Incomplete or incorrect forms will be returned for completion.

Employer Group Information – For employer group requesting disclosure of information ("Group Health Plan")			
Name		**Corp ID / C#**	

Vendor Information – Group Health Plan hereby authorizes Harvard Pilgrim to disclose its information to the following vendor ("Vendor") and for Vendor to act on its behalf for purposes related to the administration of the Group Health Plan:	
Company Name	
Street Address	
City, State, Zip Code	
Role	☐ Broker/Consultant ☐ Third-party administrator ☐ HRA/FSA/HSA vendor ☐ COBRA administrator ☐ Other *(please specify)*:
Additional Authorizations	☐ Online broker portal access (including enrollment and reporting) ☐ Online billing access (for Brokers only)

Terms of this Authorization

1. Group Health Plan and Vendor shall comply with all applicable state and federal regulatory and statutory requirements, including HIPAA, related to the protection of the disclosed information, including the execution of business associate contracts when required by HIPAA.
2. Group Health Plan acknowledges and agrees that, consistent with HIPAA requirements, Harvard Pilgrim will provide Vendor with the minimum amount of information necessary for the intended business purpose, as reasonably determined by Harvard Pilgrim.
3. If the requested disclosure includes more than summary or enrollment information, Group Health Plan's Plan Sponsor agrees to sign a *Plan Sponsor Certification* before Harvard Pilgrim will disclose such information.
4. Group Health Plan acknowledges that Harvard Pilgrim will not disclose identifiable claims information to an HSA vendor without authorization from the Group Health Plan's individual members.
5. Group Health Plan will notify Harvard Pilgrim immediately, in writing, of a revocation to this Authorization. Harvard Pilgrim may continue to provide information to Vendor if it is not informed in writing of such revocation.

Signature

I have read and understand the terms of this Authorization and I hereby authorize the disclosure of Group Health Plan's information in the manner described above. I represent that the signature below is my own and that I am legally authorized to sign this document.

Authorized Signature _____ **Date** _____

Printed Name _____ **Title** _____

Email Address _____ **Phone Number** _____