

Agreement for Fully Insured Enrollment Disclosure Request Form

Group Name: _____

Group Number(s): _____

Group Policy Maker Name and title: _____

Group Leader Name: _____

EMPLOYEES: The following list includes all employees, classes of employees, and/or other workforce members who may receive members' information relating to enrollment and disenrollment. Please indicate if the individual is an addition or deletion. If more space is needed, please attach a separate sheet of paper. Please note that the effective and termination dates of the employees for which they can receive information will be the date that the form is received Significa Insurance Group, Inc.

Add	Delete	Name of Employees or Classes of Employees

BROKERS / THIRD PARTY ADMINISTRATORS: The following Brokers and/or Third Party Administrators are entitled to request and receive enrollment and disenrollment information directly from Significa Insurance Group, Inc. Please indicate if the individual is an addition or deletion. If more space is needed, please attach a separate sheet of paper. Please note the effective and termination dates of the Brokers / Third Party Administrators for which they can receive information will be the date that the form is received by Significa Insurance Group, Inc.

Add	Delete	Entity Name along with name of employee or class of employees

The Group understands that this Assignment is subject to the approval of Significa Insurance Group, Inc.'s Privacy & Security Office before any members' enrollment and disenrollment information may be disclosed.

Completed by: (Please note – The Group Leader or Policy Maker listed on the top of this form must complete this section in order for the form to be valid.)

Name: _____ Date: _____

Title: _____ Telephone: _____

Address: _____

Signature: _____

Please return documentation to the following address:

Privacy & Security Office
 Significa Insurance Group, Inc.
 19 N. Main Street
 Wilkes-Barre, PA 18711
 Fax this form to: 570-200-1760