

## Agreement for Self Funded Disclosure Request Form

**Group Name:** \_\_\_\_\_  
**Group Number(s):** \_\_\_\_\_  
**Policy Maker Name:** \_\_\_\_\_  
**Group Leader Name:** \_\_\_\_\_

**EMPLOYEES:** The following list includes all employees, classes of employees, and/or other workforce members who may receive Plan Participants' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the plan in the ordinary course of business. Protected Health Information may only be released to individuals who are identified on the below list. 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 by 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 Protected Health Information directly from Significa Insurance Group, Inc. The type of information each entity can receive is indicated next to the entity name. Types of information include, all PHI, claims information, enrollment information. Please indicate if the entity/employee 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	Employee Name	Type of Information Authorized

The Group Health Plan understands that this Assignment is subject to the approval of Significa Insurance Group, Inc.'s Privacy & Security Office before any Plan participant's Protected Health 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