HEALTH TRADITION
P.O. Box 21171 | Eagan, Minnesota 55121 | 877.832.1823 | healthtradition.com

DESIGNATION OF INSURANCE REPRESENTATIVE
SHARING OF HEALTH INFORMATION

If you are an adult and you want an immediate family member (spouse, parent, step-parent, child, sibling, or domestic partner) to handle **all** insurance issues for you, sign the **Designation of an Insurance Representative** form.

After you sign this form, we can answer **all** questions about your insurance and your protected health information.

Use the **Authorization to Share Health Information with a Third Party** form if:

- You want to share your health information with someone else (a union representative, attorney, friend, employer, bank, etc.)
- You want to share specific health information with immediate family. For example, you want your spouse to have information about a specific operation only (not all of your health information).

INSTRUCTIONS FOR COMPLETION

1. Please print or type.

2. Use blue or black ink.

3. **Participant/Subscriber's Name:** Whose information do you want to share? Your name or your adult dependent's name.

4. **Address, Phone Number:** Your (or your adult dependent's) address and phone number.

5. **Birth date:** Your (or your adult dependent's) birth date.

6. **Designated Insurance Representative:** Which immediate family member(s) will have access to your health information? Write the name, address, and phone number.

7. **Dates Covered:** This designation authorizes Health Tradition to disclose and discuss past, present, and future information with the person(s) designated for as long as I am covered under a Health Tradition plan, unless I revoke this designation.

8. **Participant/Subscriber's Signature:** Signature of individual authorizing disclosure.
   - For an adult who cannot sign, the spouse/parent/legal representative must sign the form and write why they are signing (disability or health condition).

9. **Date:** What is the date you are signing the form?

10. Send the completed form **to the department that asked you to complete the form.**
    - Beside the name of the department, write "Authorization" on the envelope.
    - Send it to Customer Service if you don't know the name of the department.

Address envelope: Health Tradition
Attn.: **Customer Service**—***Authorization***
P.O. Box 21171
Eagan, MN 55121

Or Fax: (608) 781-9654

HEALTH TRADITION

P.O. Box 21171 | Eagan, Minnesota 55121 | 877.832.1823 | healthtradition.com

DESIGNATION OF INSURANCE REPRESENTATIVE
SHARING OF HEALTH INFORMATION

Please print or type and use blue or black ink.

Name of Participant/Subscriber _____ Participant/Subscriber Birth Date _____

Address (Street, City, State, Zip Code) _____ Subscriber Number/Group Number _____

DESIGNATED INSURANCE REPRESENTATIVE(S):

NAME(S) _____

ADDRESS _____

CITY, STATE, ZIP CODE _____

PHONE NUMBER _____

RELATIONSHIP TO ME _____

I give permission for the person(s) above to be my insurance representative for all questions about my Health Tradition coverage or benefits. I give Health Tradition permission to share all of my information with the person(s) on this form, including confidential medical information, mental health, alcohol/drug abuse, and developmental disabilities.

Reason: I want the person(s) on this form to handle all questions and issues about my eligibility for coverage, plan benefits, payment of claims, preauthorization of treatment, appeals, and grievances under any Health Tradition policy. I understand I can also talk to Health Tradition myself.

Dates Covered: This form gives Health Tradition permission to talk about past, present, and future information with the person(s) listed above, for as long as I am covered under a Health Tradition plan. I understand that I can stop this permission.

Redisclosure Policy: I understand that after Health Tradition shares my information with my insurance representative, the information is not protected by federal and state privacy standards. Health Tradition is not responsible if my insurance representative shares my information with someone else.

I understand that I do not have to sign this form. I understand that I can always talk to Health Tradition myself. I give Health Tradition permission to treat the person(s) listed on this form as my insurance representative(s) as described above.

Participant/Subscriber's Signature _____ Date _____

If individual is 18 or older and not signing, please state reason (i.e., disability or health condition) why individual cannot sign and signer's relationship to individual:

_____

Send the completed form to: **Health Tradition**
P.O. Box 21171
Eagan, MN 55121

Fax: (608) 781-9654