

26+ EMPLOYEE/GROUP APPLICATION AND AUTHORIZATION

EMPLOYEE NAME (LAST, FIRST, M.I.)	GENDER M/F	SOCIAL SECURITY NUMBER
Address (number)	(street)	(city)
(state)	(zip)	
County	Home Phone	Date of Birth
Company Name and Address		Date of Hire
Marital Status		Spouse's Name
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Does your spouse have other health coverage?	Name and address of Spouse's Employer:	
<input type="checkbox"/> Yes <input type="checkbox"/> No		

NOTICE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Athens Area Health Plan Select, Inc., or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

I authorize the use/disclosure of any and all individually identifiable health information, including medical records, reports, pharmaceutical records, diagnostic testing, lab work, and other medical information.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution, or person, that has any records or knowledge of me or my health, to give to Athens Area Health Plan Select, Inc., and its reinsurers, any and all such health information. I understand that the following parties may need to collect information on me in regard to proposed insurance coverage: Athens Area Health Plan Select, Inc., its reinsurers, any insurance support organization, any consumer reporting agency, and all persons authorized to represent these organizations for this purpose. Those parties may disclose information to the following: other insurers to which Proposed Insured has applied or may apply; reinsurers; pharmacy benefit managers; physicians; hospitals; clinics.; or other medically related facilities, health care clearing houses or persons who perform business, professional, or insurance tasks for them. They may disclose information as allowed or required by law.

I understand that this information will be used to make eligibility and risk rating determinations, to locate or underwrite insurance for me, or to determine whether a valid claim for benefits has been made.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal or state privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this Authorization.

I understand that I may revoke this Authorization in writing at any time by contacting Athens Area Health Plan Select, Inc., 295 West Clayton Street, Athens, Georgia 30601. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the Authorization prior to receiving notice of my revocation. Unless revoked this Authorization will be valid for thirty months from the date of my signature. (SIGNATURES ARE REQUIRED FROM ALL APPLICANTS AGE 18 AND ABOVE.)

DATE

SIGNATURE OF PROPOSED INSURED

DATE

SIGNATURE OF SPOUSE OR DEPENDENT

DATE

SIGNATURE OF DEPENDENT (age 18 or older)

DATE

SIGNATURE OF DEPENDENT (age 18 or older)

DATE

SIGNATURE OF AUTHORIZED PERSON
ON BEHALF OF PROPOSED INSURED