The Address/Fax #/Phone # listing for the Benefit Plans is attached.

HIPAA Privacy Authorization Form

NCFlex Program

Please Print

Individual's Name: _____ **Social Security #:** ___ – ___ – ____

Day Phone #: (___) _____

Employee's Name: _____ **Social Security #:** ___ – ___ – ____
(if different from Individual's Name above)

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that if the person or organization authorized to receive the information is not a health plan or health care provider, the released information may be further disclosed and may no longer be protected by the federal privacy regulations.

1) **Entity Authorized to Disclose Your Health Information**

- ☐ Dental Plan
- ☐ Supplemental Medical Plan
- ☐ Health Care FSA Plan/ NCFlex Department
- ☐ Vision Plan

(Check Appropriate Boxes)

2) **Entity Authorized to Receive Your Health Information**

- ☐ Benefit Representative's Name: _____ Work#: _____
- ☐ NCFlex Department
- ☐ Aon Consulting (Program Advisor)
- ☐ Other: Name: _____ Relationship: _____

(Check All That Apply)

3) **Describe the Details of Your Health Issue/Question to be Investigated and Disclosed**: _____

_____

_____

_____

4) **Unless Otherwise Revoked in Writing, this Authorization will Expire on:**

- ☐ The following date: ____/____/____
- ☐ When the issue/question has been resolved

(Check Only One Box)

- You may revoke this Authorization at any time by providing written notice to your Benefit Representative named in section #2 above or to the NCFlex Department, Office of State Personnel, 116 West Jones Street, Raleigh, NC 27603. Your revocation will not affect any actions already taken in reliance on this authorization.
- You may refuse to sign this Authorization which will not affect your ability to enroll in a health plan, obtain health care treatment or payment, or eligibility for benefits.
- You may inspect or copy any information to be used or disclosed under this Authorization.

_____ _____
Signature of Individual (or Personal Representative) Date

_____
(Print) Individual's Name

_____ _____
(Print) Name of Personal Representative (if applicable) Describe your Authority to Act for

_____
the Individual (e.g., parent of minor, power of attorney, executor of estate, etc.)

Where To Send The HIPAA Privacy Authorization Form

DENTAL
North Carolina Mutual Attention: *NCFlex* Enrollment 3737 Glenwood Avenue, Suite 100 Raleigh, NC 27612 Phone Number: 1-888-562-5421 Fax Number: (919) 573-6082

HEALTH CARE SPENDING ACCOUNTS
Aon Consulting Attention: *NCFlex* Enrollment Flex Administration #00001-80 PO Box 2845 Winston-Salem, NC 27102-2845 Phone Number: 1-800-726-3221 Fax Number: (336) 728-2980

SUPPLEMENTAL MEDICAL
Kanawha Insurance Attention: *NCFlex* Enrollment PO Box 7200 Lancaster, SC 29721-7200 Phone Number: (877) 378-1505 Fax Number: (803) 283-5549

VISION
Superior Vision Services Attn: HIPAA Coordinator 11101 White Rock Road, Suite 150 Rancho Cordova, CA 95670 Phone Number: 1-800-923-6766 Fax Number: 1-800-777-1811

NCFLEX OFFICE	
Main Contacts: Laura Rubin/ Chandra Lockley	Flexible Benefits Program Office of State Personnel 1331 Mail Service Center Raleigh, NC 27699-1331
Second Contact: Pani Tademeti	Courier 51-01-03 Phone Number: (919) 733-6316 Fax Number: (919) 733-0325