The Federal Employees Dental and Vision Insurance Program (FEDVIP)

Authorization for Disclosure of Information

P.O. Box 797 | Greenland, NH 03840-0797 | **1-877-888-FEDS** (1-877-888-3337) **TTY** 1-877-889-5680

Insured's name

First name M.I. Last name

Address 1

Address 2

City State/Territory

Country Zip/Foreign postal code

Date of birth Month / Day / Year

BENEFEDS User ID (optional)

I, the applicant or insured named above, authorize Long Term Care Partners, LLC (LTCP), the company that handles enrollment and premium administration for the Federal Employees Dental and Vision Insurance Program (FEDVIP) via BENEFEDS, to disclose information about my enrollment under FEDVIP, including demographic information, billing and payment information, and other information related to FEDVIP, to the individual(s) listed below. This will allow such individual(s) to assist me in matters related to my enrollment under FEDVIP.

Name Relationship Phone number

Name Relationship Phone number

I understand that this authorization is voluntary. Unless I revoke the authorization, I understand that it is valid until the later of 1) one year from the date this form is signed (if I do not yet have coverage nor become insured) or 2) one year from the date I no longer have coverage under the applicable account (if I am currently insured or become insured), at which time it will expire. I understand that I may revoke this authorization at any time by notifying the BENEFEDS department at LTCP in writing at: **BENEFEDS Attn: HIPAA Privacy Office, P.O. Box 797, Greenland, NH 03840-0797**. Revoking this authorization will have no effect on any information released in reliance on this authorization before BENEFEDS received the revocation. I further understand that BENEFEDS will not condition enrollment on whether I sign this authorization.

I understand that the individual(s) listed above may redisclose any information received. Once information is disclosed to the individual(s), I understand that the information may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) regulations and other applicable privacy laws.

Signature (insured or legal representative) _____

Date signed _____ / _____ / _____
(mm/dd/yyyy)

If signed by a personal representative of the insured, please describe the authority under which the representative is authorized to act and enclose any related documentation (e.g., copy of financial power of attorney):

Return your completed form to:

BENEFEDS, Attn: HIPAA Privacy Office | P.O. Box 797 | Greenland, NH 03840-0797 | Fax: 1-833-889-3666