Discovery Benefits®
FSA • HSA • HRA • COBRA • Transportation

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COBRA Authorized Representative/HIPAA Form

This form is to document the designation of one or more Authorized Representatives for a participant. This form authorizes the release of COBRA information to the named representative(s). This authorization does not provide your Authorized Representative(s) with any authority, either implied or direct, over any benefit decisions or account management. If you wish to set up a power of attorney or living will, please discuss this with your attorney. We will not condition benefit payments, enrollment or eligibility for benefits on the execution of this form.

Step 1: Primary Qualified Beneficiary Information

*=Required Fields

*Previous Employer (Do not abbreviate)

*Primary Qualified Beneficiary Name (First, MI, Last)

*Social Security Number

Street Address

City

State

Zip

*Day Telephone

Email Address

Step 2: Authorized Representative Information

*Authorized Representative Name — Day Telephone

*Authorized Representative Name — Day Telephone

*Authorized Representative Name — Day Telephone

*Authorized Representative Name — Day Telephone

Step 3: Expiration & Revocation and Authorized Use & Disclosure

I understand that due to HIPAA regulations Discovery Benefits will not disclose my personal health information to other parties without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named above for the purpose of assisting with, or facilitating, the coordination or payment of my health benefits. I also understand that if one of my Authorized Representatives is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my Authorized Representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

I understand I have the right to revoke or end this authorization at any time. I understand that if I do not wish the person(s) named in Step 2 to remain my Authorized Representatives, I must revoke this authorization in writing by giving written notice of my decision to Discovery Benefits, Inc. I understand that my revocation of this authorization will not affect any action that you have taken or any information that you have already released based upon this authorization before you actually receive my request to revoke it.

Further, I understand this authorization will terminate 12 months from the date of signature below.

*Primary Qualified Beneficiary Signature

*Date

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