REQUEST BY MOREHEAD STATE UNIVERSITY EMPLOYEE BENEFIT PLAN FOR AUTHORIZATION TO USE OR DISCLOSE INFORMATION

The MOREHEAD STATE UNIVERSITY EMPLOYEE BENEFIT PLAN (the Health Plan") is sponsored by MOREHEAD STATE UNIVERSITY (the "Employer"). I hereby authorize the Health Plan to use or disclose my individually identifiable health information as described below. **I understand this authorization is voluntary. I understand that if the organization or persons authorized to receive the information is not another health plan or a health care provider, the released information may no longer be protected by federal privacy regulations.**

Who May Use or Disclose Information:

The Health Plan (referred to as "we" or "us" in this Authorization) and those employees of the Employer responsible for administering the Health Plan may need to use or disclose to third parties individually identifiable health information about you for the purposes described in this Authorization.

What Information We May Use Or Disclose:

The information that we may use or disclose to third parties includes: (1) any enrollment form you complete as part of the Health Plan's enrollment or re-enrollment process (including any medical questions on that enrollment form), and (2) any medical questionnaires or similar forms you may be asked to complete by an insurance company, stop-loss insurance company, reinsurer or health maintenance organization as part of the enrollment or re-enrollment process. We call this "Enrollment Information." It also includes any information the Health Plan receives from you, your health care providers or other health plans that we need to permit us to file and process a claim for reimbursement we or the Employer may have with a stop-loss insurance company or reinsurer that provides coverage to the Health Plan or Employer. We call this "Claims Information."

Reasons We May Use Or Disclose This Information:

Enrollment Information may be used by the Health Plan, insurance companies, stop-loss insurance companies, reinsurers or HMOs: (a) to make eligibility or enrollment decisions about you; (b) for underwriting or risk rating determinations; (c) to make decisions about purchasing, renewing or replacing health insurance contracts; or (d) to obtain stop-loss coverage or a reinsurance contract (including a stop-loss contract to be issued to the Employer). Claims Information may be used by the Health Plan or Employer to permit us to file and process a claim for reimbursement we may have with a stop-loss insurance company or re-insurer that provides coverage to the Health Plan or Employer.

People to Whom We May Disclose This Information:

We may disclose the Enrollment Information and Claims Information to insurance companies, stop-loss insurance companies, reinsurers or HMOs for the purposes described above. We may also provide Enrollment Information and Claims Information to certain employees of the Employer to permit the Employer to administer the Health Plan or to obtain reimbursement from a stop-loss insurance company or reinsurer.

Additional Information:

You will be provided with a copy of this form after you sign it. This Authorization will expire on the later of the date you are no longer enrolled in the Health Plan or the date you no longer have any claim for benefits or coverage under the Health Plan. You may revoke this Authorization at any time by notifying the Health Plan in writing, but if you do it won't affect any actions we took before we received the revocation. You will not be permitted to enroll in the Health Plan and receive benefits from the Health Plan if you do not sign this form (or if you sign it and later revoke it), unless we request to use or disclose your psychotherapy notes.

_____ _____

Signature of Enrollee or Enrollee's representative **Date**

Printed Name of Enrollee (if applicable): _____

Printed Social Security number of Enrollee: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION; HOWEVER, IF YOU REFUSE, YOU WILL NOT BE PERMITTED TO PARTICIPATE IN THE HEALTH PLAN