BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Authorization for Disclosure of Protected Health Information

This authorization will permit Blue Cross and Blue Shield of Alabama and its business associate(s) on behalf of your Health Plan to disclose your health information that you describe below ("Protected Health Information") to the persons or entities and for the purpose that you describe below. **Please read and complete the following, and return to Blue Cross and Blue Shield of Alabama, PO Box 10485, Birmingham, Alabama 35202-0485.**

A. The Individual Who is The Subject of The Protected Health Information.

Note: A separate authorization form must be completed by each individual (or his/her personal representative) who desires to request that Blue Cross and Blue Shield of Alabama and its business associate(s) on behalf of his/her Health Plan disclose his/her Protected Health Information as described in this authorization.

Name:	**Contract Number:** (as it appears on your Health Plan ID Card)	**Social Security Number:**
Address:	**Date of Birth:** (MMDDYYYY)	**Telephone Number:**

B. Description of My Protected Health Information To Be Disclosed.

Note: Please insert your initials in front of the paragraph below (1, 2, 3 or 4) that applies to the description of your Protected Health Information to be disclosed pursuant to this authorization. If you initial paragraph 2, 3 or 4 please complete additional details requested.

1. _____	**Any or all of my Protected Health Information that may be requested from time to time by the person(s) I identify in Section D. below.**
2. _____	**All my Protected Health Information related to one or more of the following:**
	Description of Claim:
	Time frame(s) of Service:
	Name of Provider:
3. _____	**All my protected health information related to:**
	Date of Accident/Incident:
	Type of Accident/Incident:
	Member's Injury:
4. _____	**Other. Here is a specific description of my Protected Health Information to be disclosed:**

C. Person(s) Authorized To Disclose My Protected Health Information.

By signing this authorization, I hereby authorize Blue Cross and Blue Shield of Alabama and its business associate(s) on behalf of my Health Plan (identified by the Contract Number above) to disclose my Protected Health Information. **I understand that information contained in my protected health information may include information related to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.**

_____

D. Person(s) Authorized To Receive My Protected Health Information.

Name(s):	
Address(es):	
Telephone(s):	

By signing this authorization, I understand that my Protected Health Information described herein may be redisclosed by the person(s) I have authorized to receive and use my Protected Health Information and that my Protected Health Information described herein may no longer be protected by federal privacy laws.

E. Purpose of This Disclosure of My Protected Health Information.

☐ **At my request**	☐ **Litigation** (Style of Case & Number): _____	☐ **Other** (Please Specify): _____

(Continue on back)

F. Date of Expiration of this Authorization.

☐	Until my coverage under my Health Plan (identified by the Contract Number above) terminates.
☐	Expiration Date or Event:

If no expiration date is indicated, this authorization will expire in one year from the date of this authorization.

G. Right to Revoke this Authorization.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the address listed below. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before you received my written notice of revocation.

Blue Cross and Blue Shield of Alabama
Attention: Privacy Office
Post Office Box 2643
Birmingham, Alabama 35202-2643

H. Signature:

I, _____ , have had full opportunity to read and consider the contents of this authorization. I understand that my Health Plan will not condition its payment activities in connection with my claims, or my enrollment in my Health Plan, or my eligibility for benefits or treatments upon my giving this authorization.

Signature:	**Date:**
***Personal Representative Signature:**	**Date:**

* If signed as a Personal Representative, you must describe your authority to act as the Personal Representative of the individual who is the subject of the Protected Health Information described in this authorization ("Individual") **by initialing one of the following:**

_____	The Individual is an unemancipated minor child, I am the parent and have authority under applicable law to act on behalf of the Individual in making decisions related to health care, and the health information described herein is relevant to my personal representation of the Individual. ***Please Note: You should consult your state's laws to find out if you have legal authority to make health care decisions for your child. If you are unsure whether you have such legal authority, both you and your child must sign this treatment. For example: In the State of Alabama a child 14 years old or older has the authority to make healthcare decisions and must sign this authorization.***
_____	The Individual is an adult, unemancipated minor or emancipated minor, I am the guardian, attorney-in-fact or other authorized representative and have authority under applicable law to act on behalf of the Individual in making decisions related to health care, and the health information described herein is relevant to my personal representation of the Individual. ***Attached is a copy of the legal document(s) that give me authority to act as a Personal Representative, such as letters of guardianship.***
_____	The Individual is deceased, I am the executor, administrator or other person authorized under applicable law to act on behalf of the Individual's estate, and the health information described herein is relevant to my personal representation of the Individual or the Individual's estate. ***Attached is a copy of the legal document(s) that give me authority to act as a Personal Representative, such as letters testamentary or letters of administration.***

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS AFTER YOU SIGN IT.

ELIGIBILITY: COORDINATION OF BENEFITS

For coordination of benefits purposes, will any person listed on this application be covered under another health plan or contract ***at the time this policy becomes effective?*** If yes, please provide the information below. Use additional paper if necessary.

NAME OF CONTRACT HOLDER/DEPENDENT	EFFECTIVE DATE OF OTHER COVERAGE (MM/DD/YYYY) MM/DD/YYYY
NAME OF INSURANCE COMPANY	POLICY, ID, CONTRACT OR CERTIFICATE NUMBER
GROUP NUMBER	TYPE COVERAGE: ☐ INDIVIDUAL ☐ FAMILY

ELIGIBILITY: MEDICARE

Is any person to be insured enrolled in any part of Medicare (Parts A, B, C or D)? ☐ YES ☐ NO	If yes, give name of person:	MEDICARE NUMBER It may be to your advantage to enroll in a Medicare supplement or a Medicare Advantage plan. Please visit us at **bcbsalmedicare.com** to review your options.

PAYMENT & BILLING

We will accept your premium payments only if they are made from your personal **(non-business)** account. Premiums are payable in advance on a monthly basis.

PREMIUM – I agree to pay you in advance the monthly premium in the amount due before the 1st day of the coverage effective date.
Please choose either an Automatic Payment Method OR a Billing Method.
Failure to choose either an Automatic Payment Method or a Billing Method will delay the processing of your application.

PREFERRED EFFECTIVE MONTH

MONTH MM/YYYY

Please note that if your preferred effective month is not available for any reason, your contract will be effective on the next available month based on applicable guidelines.

AUTOMATIC PAYMENT METHOD

Select **ONE** payment method.

☐ **E-Check**

☐ **Debit**

☐ **Credit Card**

Please complete the included Payment Authorization Agreement and submit it along with this application. If approved, your payment will be charged monthly to your account. It may take up to 30 days to implement automatic payment. You will receive a bill for your premiums until your payment method is established. Courtesy notification will be sent to your email.

For e-check only, please mail a blank voided check to:

Blue Cross and Blue Shield of Alabama
Attention: Payment Processing Department
P.O. Box 11551
Birmingham, Alabama 35282-9722

BILLING METHOD

Select **ONE** billing method.

☐ **E-Statement**
You will receive an email notification each month when your billing statement is available. Email address is required.

☐ **Billing Statement**
You will receive a billing statement each month which includes an invoice to return with your premium payment. Courtesy notification will be sent to your email.

BINDING ARBITRATION NOTICE

THE CONTRACT YOU ARE APPLYING FOR INCLUDES FINAL AND BINDING ARBITRATION. THIS MEANS ANY DISAGREEMENT NOT SETTLED BY THE EXTERNAL REVIEW PROCESS DESCRIBED IN THE HEALTH PLAN BOOKLET WILL BE SETTLED BY ARBITRATION—NOT A COURT. THE ARBITRATOR'S DECISION IS BINDING. AN ARBITRATOR IS AN INDEPENDENT, NEUTRAL PARTY WHO MAKES A DECISION AFTER LISTENING TO BOTH PARTIES. THE DECISION OF THE ARBITRATOR CAN'T BE REVIEWED BY A COURT, EXCEPT IN CERTAIN CIRCUMSTANCES AS DESCRIBED IN THE CONTRACT. THE ARBITRATOR ACTS AS JUDGE AND JURY. BY SIGNING BELOW YOU AGREE TO SETTLE ANY DISAGREEMENT BY ARBITRATION INSTEAD OF A COURT TRIAL.

AGREEMENT TO ARBITRATE - AFTER READING THIS, I AGREE TO THE ARBITRATION PROVISIONS IN THE CONTRACT.

I acknowledge by my signature that I have read and understand the front and back of this application, that all statements made by me are true and complete, and that I agree to **binding arbitration** with respect to the health plan as described in this application and my Blue Cross and Blue Shield of Alabama health plan contract booklet.

THIS APPLICATION IS NOT COMPLETE UNLESS IT IS SIGNED AND DATED.

APPLICANT'S SIGNATURE — DATE SIGNED MM/DD/YYYY