PLAN SPONSOR ELECTION
REGARDING RECEIPT OF PROTECTED HEALTH INFORMATION (PHI)

As the Plan Sponsor of a fully insured group health plan, you may choose whether or not you want to receive Protected Health Information (PHI), as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations, with respect to your employees and their dependents covered under the group health plan that you sponsor.

If you choose to receive the PHI of individuals covered under the group health plan that you sponsor, you will be required to execute the attached Plan Sponsor Certification and return it to us. You will also be required to amend your Plan Document using the Plan Amendment attached to the Plan Sponsor Certification or a substantially similar amendment. Please understand that electing to receive PHI requires you by law to implement processes and safeguards that you will not be required to implement should you elect not to receive PHI. We suggest that you thoroughly understand those legal requirements before making this election.

If you elect **not** to receive PHI, we may still provide you summary health information, de-identified health information and enrollment and disenrollment information as those terms are defined in HIPAA and for the purposes described in HIPAA.

Plan Sponsor Election

_____ **No, I do not want to receive any PHI.** Summary health information, de-identified health information and enrollment and disenrollment information may be provided, in accordance with HIPAA, to the Authorized Representative(s) listed below. I understand that I must provide written notice to Trustmark immediately if there is a change to the List of Authorized Representatives.

LIST OF AUTHORIZED REPRESENTATIVES
(For Summary health information, de-identified health information and enrollment and disenrollment information)

Name: _____ Name: _____
Title: _____ Title: _____

_____ **Yes, I want to receive PHI.** I have executed the Plan Sponsor Certification and instituted the Plan Amendment. The individuals that I authorize to access PHI are listed below.

LIST OF AUTHORIZED REPRESENTATIVES
(See Key on the following page to identify the type of PHI he/she is authorized)

Name: _____ Title: _____

Primary Function(s)* with regard to the group health benefit plan:
☐ LMTD ☐ CLMS 1 ☐ CLMS 2 ☐FINANCE ☐OTHER, if "other" please explain: _____

Name: _____ Title: _____

Primary Function(s)* with regard to the group health benefit plan:
☐ LMTD ☐ CLMS 1 ☐ CLMS 2 ☐FINANCE ☐OTHER, if "other" please explain: _____

Name: _____ Title: _____

Primary Function(s)* with regard to the group health benefit plan:
☐ LMTD ☐ CLMS 1 ☐ CLMS 2 ☐FINANCE ☐OTHER, if "other" please explain: _____

If additional appointments for Authorized Representatives are needed, please request use the "List of Authorized Representatives Form".

KEY:

LMTD: Limited access - an individual who works with enrollment, termination, COBRA, etc. – needs no additional health information)

CLMS 1: Individual who needs to check status of claims – minimal PHI to include eligibility information

CLMS 2: Assists participants in filing claims or appeals on claims denials – should have access to all claims data, including eligibility, upon request)

FINANCE: Individual to whom we are to deliver reports related to financial maintenance of the coverage (e.g. check register, etc.)

One of the HIPAA administrative requirements for a Covered Entity, that has elected to receive PHI, is for the appointment of a Privacy Official. Please provide this official's name and contact information should we need to contact him/her:

Privacy Official Name: _____

Contact email: _____

Contact phone: _____

Plan Sponsor / Employer Name: _____

Authorized Signature: _____

Printed Name: _____

Title: _____

Date: _____