

## Designation of Authorized Representative - Group

PO Box 1739 Boise, ID 83702-5809

Use this form to appoint someone as an Authorized Representative. When you appoint someone as an Authorized Representative, they can act on the Group's behalf. They will also have access to the Group's protected health information (PHI) as it relates to the topic(s) you specify below. Please note we cannot share any information about your Group with anyone else, nor can anyone else act on the Group's behalf, unless we receive a signed copy of this form.

Employer Name (print)		Group ID #
Employer Contact Name		Employer Telephone Number
Employer Address (Street name, City, State, Zip Code)		Employer Email
	Plan to recognize the person named and to disclose relevant health inforn	
Name of person or agency representing Group		Telephone Number
Street Address		City, State, Zip Code
All Medical claims	All Dental claims	
All Appeals	Group Portal access (	management of group enrollment, group premiums and more):
such information as confidential. I u Authorized Representative Form t signed below unless a different exp	ınderstand that I may revoke this A	
Signature		Date

## **Printed Name**

A copy of this authorization form will be sent to the employer at the address listed above.