

**HIPAA AUTHORIZATION FORM FOR PRE-ENROLLMENT  
USES AND DISCLOSURES OF MEMBER INFORMATION**



**Plan Type:**  Employer Group     Medicare Supplement/SELECT     elite1 Individual  
**Applican Type:**  New Applicant     Existing Sanford Health Plan Member

I hereby authorize the use or disclosure of personal health information about me as described below.

1. I authorize Sanford Health Plan to use the personal health information I have provided on the application form to determine my eligibility to obtain coverage under the health benefits plan, for which I have applied, and to determine the rates and terms which apply to the plan/policy.
2. I also authorize all health care providers and pharmacy benefit managers who have provided treatment or other health care services to me to disclose all information regarding my treatment to Sanford Health Plan.
3. The following group of persons employed or working for Sanford Health Plan may use my personal health information which is described above: employees of the Underwriting and Member Services departments.
4. The information which is disclosed by health care providers described above may be used by Sanford Health Plan to determine my eligibility to obtain coverage under the health benefits plan, for which I have applied, and to determine the rates and terms which apply to the plan/policy.
5. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Sanford Health Plan in reliance on this authorization, by sending a written revocation to Sanford Health Plan, Attn: Member Services, PO Box 91110, Sioux Falls, SD 57109-1110.
6. This authorization will expire when Sanford Health Plan has approved or denied my application to enroll in the health benefits plan.
7. I understand that the information which will be provided under this authorization is necessary for Sanford Health Plan to determine my eligibility for coverage under the health benefits plan and that Sanford Health Plan will condition enrollment in the health benefits plan/policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
8. I understand that if the person or entity that receives my personal health information is a not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. In the case of this authorization, however, the information described above will be received by a health plan which is covered by the federal privacy regulations, and will not be used or redisclosed except as described above, and the information will continue to be protected under the federal privacy regulations

|  |   |      |                        |
|--|---|------|------------------------|
| Applicant Name (or Legal Representative <sup>1</sup> ) | Signature                                   | Date | Social Security Number |
| Spouse Name  | Signature                                   | Date | Social Security Number |
| Dependent Name   | Signature <sup>2</sup> (if age 18 and over) |      | Social Security Number |
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<sup>1</sup> If you are the legal representative of the applicant and are not the parent of a minor, you must attach evidence of your authority to act as the applicant's representative for this authorization to be valid (i.e. Power of Attorney)

<sup>2</sup> If under the age of 18. The parent or guardian must sign on the child's behalf and indicate their relationship next to their signature.

**Please attach the white copy to your enrollment application.**

**White copy: Health Plan    Yellow copy: Human Resources    Pink copy: Applicant**