# AUTHORIZATION TO RELEASE HEALTH INFORMATION AND CHECKS OF ADULT DEPENDENT TO PRIMARY PARTICIPANT

This form is for use by a covered individual under the Health Plan who is eligible as an adult dependent ("Dependent") and who wishes to:

(1) have all of his/her/their Health Plan mail (including EOBs and other claims information) sent to his/her/their parent or spouse specified in Section C of this form who is a primary Plan participant (the "Primary Participant") and permit the Primary Participant to access the Dependent's EOB and other claims information, including online via the myPHP portal (the "Portal"); and/or

(2) have his/her/their checks made out to the Primary Participant specified in Section C of this form. This will enable the Primary Participant to review such mail and access such claims information (including on the Portal) and/or deposit or cash such checks on behalf of the Dependent based on the Dependent's selection(s) in Section A below.

## Instructions

This form is divided into five sections. Please review and complete each section according to the instructions below.

- **Section A: Authorizations.** Check the boxes applicable to the authorizations granted with this form.
- **Section B: Dependent's Information and Signature.** Complete the information for the Adult Dependent granting authorization.
- **Section C: Primary Participant's Information and Signature.** Complete the information for the Primary Participant to whom the Adult Dependent is granting authorization to receive his/her/their health information and/or checks.
- **Section D: Return Instructions.** Follow these instructions to return pages 1 and 2 of this document.
- **Section E: Disclosures and Rights.** Read this page and retain it for future reference.

## A. Authorizations (Check at least one)

☐ **Authorization to grant access to all Health Plan and Claims information to Primary Participant**

By checking this box, the Dependent submitting this form hereby directs and authorizes the Health Plan to send all of his/her/their Health Plan mail to the Primary Participant at the address specified below, and to permit the Primary Participant to access the Dependent's EOBs and other claims information, including online via the Portal. If this box is checked and the Dependent submitting this form has established a Portal account and elected to continue to receive paper copies of Plan documents and notices (in addition to receiving electronic delivery of such documents through the Portal), such paper copies will be delivered to the Primary Participant's address specified below and such Plan documents and notices will still be provided to the Dependent through the Portal as well. If the Dependent makes the election to receive paper copies of such Plan documents and notices after submitting this form and checking this box, the Plan will send such paper copies to the Primary Participant at the address specified below unless the Dependent also submits an address change request.

☐ **Authorization to issue all checks in the name of the Primary Participant on behalf of the Adult Dependent**

By checking this box, the Dependent submitting this form hereby directs and authorizes the Health Plan to issue all of his/her/their checks in the name of the Primary Participant, including EOBs and other claims information, on behalf of the Dependent. Note that if the box above is checked but this box is not, the Health Plan will send the Dependent's checks to the Primary Participant at the address specified in **Section C** but the checks will remain in the name of the Dependent. In order for this election to become effective, this form must be agreed to, accepted and signed by the Primary Participant.

The Dependent understands and agrees that once a check is cashed or deposited by the Primary Participant pursuant to this form, the Health Plan's obligations with regard to such payments are completely satisfied and discharged and the Dependent may no longer seek such amounts from the Health Plan. The Dependent assumes all risks associated with the Dependent's directions to the Health Plan under this form and the delivery of mail and payments to the Primary Participant, and the Health Plan will not be responsible or liable to the Dependent or Primary Participant in any way for complying with this form, and will not be responsible for paying any additional amounts for claims paid to such Primary Participant.

**Please complete the back of this page.**

## B. Dependent's Information and Signature

| **DEPENDENT'S NAME:** *(Please print)* | **Dependent's Email** |
|---|---|
| The Individual listed above is the person who is authorizing the release of his/her/their Protected Health Information. | |
| **Date of Birth:** | **Last 4 Digits of SSN:** |

I have read and agree to this Authorization, including the Disclosures and the Dependent's Rights detailed on page 3.

**X** _____ _____

**DEPENDENT'S SIGNATURE** *(Required. E-Signature not acceptable.)* **Date**

## C. Primary Participant's Information and Signature

| **PRIMARY PARTICIPANT'S NAME:** | **Plan ID#:** |
|---|---|
| **Date of Birth:** | **Last 4 Digits of SSN:** |
| **Mailing Address Line 1:** | **Phone:** |
| **Line 2:** | **Add'l Phone:** |
| **Line 3:** | **Fax:** |
| **Line 4:** | **Email:** |

I have read and agree to this Authorization, including the Disclosures detailed on page 3.

**X** _____ _____

**PRIMARY PARTICIPANT'S SIGNATURE** *(Required. E-Signature not acceptable.)* **Date**

## D. Return Information

**Complete pages 1 and 2 of this authorization and return to the Plans office by email, fax or mail.**

| **E-Mail:** | **Phone/Fax:** | **Mail:** |
|---|---|---|
| demographics@dgaplans.org | Fax: (323) 866-2389<br>Phone: (323) 866-2200, Ext. 407 | Demographics Dept.<br>DGA–Producer Pension & Health Plan<br>5055 Wilshire Blvd, Suite 600<br>Los Angeles, CA 90036 |

**When transmitting information to the Plans electronically, please keep in mind that communications over the internet may not be secure and that the Plan has no control over the security of your electronic transmissions prior to receipt by the Plan. In addition, please make sure the e-mail address is correct before sending sensitive information.**

## E. PLEASE READ—Disclosures and Rights

Please read the important information below regarding this authorization:

### Disclosures

- By returning this form, the Dependent hereby authorizes the DGA-Producer Health Plan (the "Plan") to disclose certain individually identifiable health information to the Primary Participant described in Section C for the purposes of receiving and reviewing his/her/their Health Plan mail, reviewing his/her/their EOBs and other claims information (including online through the myPHP Portal) and depositing or cashing his/her/their Health Plan checks on his/her/their behalf.
- The information to be used or disclosed pursuant to this Authorization includes all of the Dependent's Health Plan mail, information and checks, including, without limitation: Enrollment Information, Health Plan Coverage Cards, Checks, Explanation of Benefits (EOBs), and other Claims Information (including such information made available through the myPHP Portal).
- The Dependent's parent or spouse specified in Section C is the participant who earned the Health Plan coverage ("Primary Participant"). If both parents have coverage through the health Plan, the Dependent's information will only be sent and made available to the Primary Participant as described in Section C.
- The Health Plan reserves the right to refuse delivery to the Primary Participant of any mail or payment, or to deny the Primary Participant access to the Dependent's EOBs and other claims information on the Portal, in the event the Plan determines, in the exercise of its sole discretion, that it would no longer be lawful to do so. In such event, the Plan will immediately notify the Dependent and will have the right to deliver the mail and/or payment directly to the Dependent.
- This form will remain in effect until the soonest of the dates described below:
    - The date this authorization is revoked by the Dependent by providing written notice to the Health Plan at the address below, or modified by the Dependent by resubmitting this form to the Health Plan with updated information (which may be done at any time). In the event the Health Plan is advised of a change in the Primary Participant's address, the Plan shall be entitled to continue sending mail and/or payments to the new address without further consent or permission from the Dependent.
    - The date the Dependent submitting this form later submits a Change of Address form or changes his/her/their address through the Portal, or
    - Three (3) years after the date the Dependent's enrollment in the Health Plan is terminated and the Dependent no longer have any Health Plan claims or appeals pending (and the Dependent has not been re-enrolled in the Health Plan prior to the expiration of such three (3) year period).

### Dependent's Rights

By signing page 2, the Dependent attests to have read and understood the following statements about his/her/their rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the Plan in writing at the address below, but the revocation will not have any effect on any actions the Plan took before it received the revocation.
- I am entitled to a copy of this authorization.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity without my authorization and without the protections of applicable privacy law.
- I understand that I am not required to sign this form to receive my health care benefits, although I must complete all applicable forms for benefits.
- I understand that I may decline to sign this authorization. However, it will be invalid if not signed.

If you have any questions regarding this form, please contact the Health Plan Department at the information below.

DGA–Producer Pension and Health Plans
5055 Wilshire Blvd, Suite 600
Los Angeles, CA 90036
Fax: (323) 866-2389
Phone: (323) 866-2200, Ext. 401