Mercer Marketplace 365+℠

Personal Information Authorization Form

This form is used to advise Mercer Marketplace 365+ Retiree of the person or persons you have chosen to have access to your personal health insurance and reimbursement account information.

Please return the completed form to Mercer Marketplace 365+ Retiree*

According to federal law, we must have your written permission (an "authorization") to use or discuss your personal medical and health insurance information with another party. You may take back ("revoke") your written permission at any time, except if Mercer Marketplace 365+ Retiree has already acted based on your permission.

Please complete the following information if you want to grant authorization for Mercer Marketplace 365+ Retiree to speak to someone other than you. This authorization is good for up to one (1) calendar year from the date of signature.

** Please complete in black or blue ink*

Section 1: Beneficiary Information (person granting authorization)

Print Full Name: _____

Print Address: (Street address, City, State, & Zip Code)

_____

_____

Telephone #: _____ - _____ - _____

Medicare #: _____ - _____ - _____ - _____

Date of Birth (mm/dd/yyyy): _____/_____/_____

Section 2: Authorized Individuals

Fill in the name(s) of the person(s) to whom you want to speak on your behalf with Mercer Marketplace.

1. Full name: _____

Address: _____

_____

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2. Full name: _____

Address: _____

_____

3. Full name: _____

Address: _____

_____

Section 3: Authorized Information

I authorize Mercer Marketplace 365+ Retiree to disclose the following information with the person(s) listed in Section 2 of this document: (*Check all that apply*)

- ☐ Information about insurance eligibility
- ☐ Information about plan enrollment (e.g. Medicare, Pre-65 Exchange, Dental, Vision, Ancillary, Short Term)
- ☐ Information about premiums and payment information
- ☐ Information about personal health history or status
- ☐ Information about reimbursement accounts (if applicable)

Section 4: Period of Authorization

Check only one (1) box below indicating how long Mercer Marketplace 365+ Retiree can use this authorization to disclose your personal information with the person(s) listed in Section 2 of this document.

- ☐ Disclose the information selected in Section 3 for one (1) year from the date of signature (Section 5)
- ☐ Disclose the information selected in Section 3 for a specified period of time only

  beginning: (mm/dd/yyyy) ___/____/_____

  ending: (mm/dd/yyyy) ___/____/_____

Section 5: Beneficiary Signature

I authorize Mercer Marketplace 365+ Retiree to disclose the personal information listed above to the person(s) named on this form. I understand that my personal health information may be re-disclosed by the person(s) named on this form and may no longer be protected by law.

Beneficiary Signature: _____

Telephone Number: _____

Date (mm/dd/yyyy): _____ / _____ / _____

☐ Check here if you are signing as the personal representative and complete the information below. Please attach the appropriate documentation (e.g., Durable Power of Attorney). This only applies if someone other than the beneficiary signed above.

Print the Personal Representative's Address (Street address, City, State & Zip Code)

_____

_____

Telephone Number of Representative: _____ - _____ - _____

Personal Representative's Relationship to the Beneficiary: _____

Send the completed, signed authorization to:

Mail:	***Email:***	***Fax:***
Mercer Marketplace 365+ Retiree P.O. Box 14401 Des Moines, IA 50306-3401	retiree.exchange@mercer.com	857-362-2999