DELTA DENTAL®

Plan Sponsor Disclosure Designee Form for Detailed Protected Health Information

This form is to be completed by the plan sponsor's authorized representative (as identified in our records) to permit disclosure of Protected Health Information, as defined by HIPAA, to specified individuals or entities. Complete this form in its entirety and return it to: Delta Dental of Virginia, Attention: Corporate Compliance, 5415 Airport Road, Roanoke, VA 24012. Phone: 540.989.8000, or toll-free: 800.237.6060. Fax: 540.491.9714. Email: Privacy.7a@corvesta.com.

SECTION A: Plan sponsor submitting designation:

Group name_____ Group number _____

Address _____

Phone_____ Email _____

SECTION B: Designated employee(s) or class(es) of employees (i.e., group administrator, HR rep, billing, etc):

Employer name or class title _____

Address _____

Phone_____ Email _____

Specifically the protected health information you are authorizing be used and/or disclosed (i.e., claims, enrollment, eligibility, etc.): _____

_____

SECTION C: Other designated persons (agents, brokers, subcontractors):

Entity name_____ Title _____

Address _____

Phone_____ Email _____

Specifically the protected health information you are authorizing be used and/or disclosed (i.e., claims, enrollment, eligibility, etc.): _____

_____

By signing below, you certify to Delta Dental of Virginia that (1) the plan sponsor named above has amended its plan documents as necessary under the HIPAA Privacy Rule (45 C.F.R. §164.504(f)(2)); (2) you are requesting the information identified above for purposes of conducting "plan administration functions" as defined in 45 C.F.R. §164.504(a); (3) the information identified above is the minimum amount of Protected Health Information necessary for plan sponsor to accomplish the purpose(s) for which the information is requested; and (4) that plan sponsor (or plan sponsor's group health plan) has engaged the designated person identified above (if any) in an "agent/subcontractor" or "business associate" agreement (as applicable). You also acknowledge that plan sponsor takes on significant responsibilities under HIPAA.

Signature of plan sponsor's authorized representative:

Signature_____ Date _____

Print name_____ Title _____