DELTA DENTAL®

Plan Sponsor Disclosure Designee Form for Enrollment or Summary Health Information

This form is to be completed by the plan sponsor's authorized representative (as identified in our records) to permit disclosure of enrollment information, summary health information, or both 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 (please print): 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 _____

This is permission to disclose: ☐ Enrollment information (information about who is enrolled in a plan)
☐ Summary health information (summary of claims history, etc)

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

Entity name_____ Title _____

Address_____

Phone_____ Email _____

This is permission to disclose: ☐ Enrollment information (information about who is enrolled in a plan)
☐ Summary health information (summary of claims history, etc)

Plan sponsor (1) authorizes the above-named individuals (or entities) to access the information identified above, (2) requests "summary health information" (if applicable) to evaluate the plan or obtain bids for alternative coverage, and (3) acknowledges that it is not entitled to more detailed Protected Health Information, as defined by HIPAA, unless otherwise agreed to by Delta Dental of Virginia by acceptance of a completed Form 14(b), as required by HIPAA. Plan sponsor agrees to promptly notify Delta Dental of Virginia of any change to the above-named individuals' (or entities') authorization to receive the information identified above and to indemnify Delta Dental of Virginia for any adverse consequences of its failure to provide such notice.

Signature of Plan Sponsor's Authorized Representative:

Signature_____ Date _____

Print name_____ Title _____