NPFBA™

NATIONAL PEACE OFFICERS AND FIRE FIGHTERS BENEFIT ASSOCIATION™

A Jointly Sponsored Long Term Care Trust of The California Law Enforcement Association® and The California Association of Professional Firefighters®

1-877-582-0003 • (209) 223-3971 • PO Box 31 • Martell, CA 95654-0031 • Fax (209) 223-2966 • www. NPFBA.org

HIPAA Authorization

Must be completed for application to be processed.

Who May Request or Use Information: This information may be disclosed to and used or disclosed by: National Peace Officers and Fire Fighters Benefit Association (NPFBA), California Public Safety Administrators, Inc. (Plan Administrators for NPFBA), ExamOne, or an evaluating physician.

Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose any and all individually identifiable health information or records about me including but not limited to medical records, reports, pharmaceutical records, drugs, diagnostic testing, and lab work: licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, pharmacy related service organization or medically related facility, the Veterans Administration, care provider or evaluators, or other organization, institution or person that has knowledge or records of me and my health.

I also agree and understand that:

- this authorization is needed for the purpose of gathering information for making eligibility, underwriting, and risk rating determinations.
- If I do not sign this authorization, my application for long-term care coverage under the NPFBA Long Term Care Plan may not be processed and my eligibility for long-term care benefits under the Plan may be denied.
- I may revoke this authorization at any time, except to the extent that:
  - action has already been taken in reliance on it before my revocation, or
  - NPFBA has a right to contest my long-term care benefits claim or coverage.
- To revoke this authorization, I must notify the NPFBA, PO Box 31, Martell, CA 95654, in writing.
  - If I do revoke this authorization, I understand that my application for long-term care coverage may not be processed and my eligibility for long-term care coverage benefits may be denied.
  - If I do not revoke this authorization, it will be valid for 36 months from the date I sign it, at which date it will expire.
- My health information may be redisclosed and may be no longer protected by applicable law, including Federal health information privacy regulations. This can occur only if such redisclosure is required or allowed by law (for example, in response to a subpoena).
- A copy of this authorization is as valid as the original.

By my signature below, I attest that I have read and understand the terms of this authorization and that I agree to the terms of this authorization.

____

Applicant Name *(Please print)*

____

Signature of Applicant

Last 4 of SS# ____________________ Date __________________________