HIPAA PLAN SPONSOR CERTIFICATION
FOR SELF FUNDED HEALTH PLAN SPONSORS

The Plan Sponsor must complete this form to certify that the group health plan documents have been amended to comply with HIPAA. **No Protected Health Information (PHI) will be released until this form is complete.**

If you sponsor a **self-funded health plan**, you must fill out this form.

By my signature below, the Plan Sponsor certifies that the governing documents for the group health plan (the "Plan") are amended to incorporate the following provisions, and that the Plan Sponsor shall:

a) not use or further disclose the PHI other than the minimum necessary information as permitted or required by the Plan or as required by law;
b) ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
c) not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Sponsor;
d) report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures described in (a) above;
e) make available to the Plan PHI to comply with the HIPAA right to access in accordance with 45 CFR § 164.524;
f) make available to the Plan PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;
g) make available to the Plan the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;
h) make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA privacy requirements;
i) if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction of the information is not feasible, limit uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
j) Ensure that the adequate separation between Plan and Plan Sponsor (i.e., the "firewall"), required in 45 CFR § 504(f) (2) (iii), is satisfied.

AUTHORIZED REPRESENTATIVES

You must provide a list of the individuals, including any agent, broker or agency who are authorized to have access to employees' PHI on behalf of the Plan for the purposes of Plan administrative functions. **ONLY THOSE WRITTEN IN THIS BOX WILL BE AUTHORIZED.** Please provide the first name, last name, title, and any agency name.

You are required to select the limit of PHI an Authorized Representative is allowed to receive. Authorized Representatives may have different access levels to employees' PHI as permitted by HIPAA. If there is a change to this list of Authorized Representatives, please contact us.

Name†	Title	PHI Access
		__LMTD __CLMS1__CLMS2__FINANCE
		__LMTD __CLMS1__CLMS2__FINANCE
		__LMTD __CLMS1__CLMS2__FINANCE
		__LMTD __CLMS1__CLMS2__FINANCE
		__LMTD __CLMS1__CLMS2__FINANCE
		__LMTD __CLMS1__CLMS2__FINANCE
		__LMTD __CLMS1__CLMS2__FINANCE
		__LMTD __CLMS1__CLMS2__FINANCE

†If additional appointments for Authorized Representatives are needed and you run out of space on this form, please request the List of Authorized Representatives Form.

Access Levels

LMTD This individual works with enrollment, termination, COBRA, etc., and needs no additional health information.

CLMS 1 This individual needs to check the status of claims, and should have access to minimal PHI, including eligibility information.

CLMS 2 This individual assists participants in filing claims or appeals, and should have access to all claims data.

FINANCE This individual should receive reports related to the financial maintenance of the coverage (e.g., check registers).

PRIVACY OFFICIAL

You are required by HIPAA to name a Privacy Official. The Privacy Official is responsible for overseeing privacy compliance. The Privacy Official will be considered an Authorized Representative unless you specify otherwise.

If the Privacy Official changes, please contact us.

Privacy Official First and Last Name: _____

Title: _____

Contact Email: _____

Contact Phone: _____

PLAN SPONSOR NAME:_____ GROUP ID NUMBER:_____

Authorized Signature:_____ Date:_____

Printed Name:_____

Title: _____