Navia Benefit Solutions
Authorization for Release of Information
WA State SEBB

Important information about your rights

- You may revoke this authorization at any time before its expiration by notifying Navia Benefit Solutions in writing. The revocation will not have any effect on any actions that Navia Benefit Solutions took before receiving the revocation.
- You may see and receive a copy of the information described on this form, if requested.
- You are not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed under this authorization may be re-disclosed by the receiving entity. If you want to protect the information from further disclosure without authorization, you may seek assurances from the recipients named below.
- If your employer is requesting the authorization, you may ask for a copy of it.

Information about this Authorization for Release of Information form:

I have read and understand the above statements about my rights. I hereby authorize the use or disclosure of my individually identifiable health information as described below. (Please sign and date on the back of this form.)

Participant Name (print): _____

Social Security Number: _____

1. Please provide a specific description of the information you would like to have used or disclosed.
   _____
   _____
   _____
   _____

2. Name the person or class of persons authorized to make the requested use or disclosure (for example, a specific customer service representative at Navia Benefit Solutions or name Navia Benefit Solutions as a class).
   _____
   _____
   _____

3. Name the person or class of persons to whom Navia Benefit Solutions may make the disclosure (for example, a spouse, interpreter, friend, or a specific payroll or benefits office as a class).
   _____
   _____
   _____

4. Describe the purpose for the requested disclosure (if you choose not to provide a statement of purpose, you can provide a general statement such as “at the request of the individual”).
   _____
   _____
   _____

5. Describe the expiration date or event for this Authorization for Release of Information (for example, the end of the plan year, or once a specific claim is resolved, etc.)
   _____
   _____
   _____

Email: customerservice@naviabenefits.com
Fax: (425) 451-7002 or toll-free (866) 535-9227
Customer Service Line: (425) 452-3500 or (800) 669-3539

6. *For Participant's Representative (if applicable), please provide a description of authority to act on behalf of the participant.* Description of Authority.
   _____
   _____
   _____

Signature:

Please sign and date before returning this form to Navia Benefit Solutions.

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Customer Service Line: 425-452-3500 or 1-800-669-3539

I understand that this authorization is voluntary. I may refuse to sign it and I may revoke it at any time in writing to Navia Benefit Solutions.

Participant Signature: _____Date: _____