DELTA DENTAL

DELTA DENTAL OF ARIZONA GROUP HEALTH PLAN AUTHORIZATION

Group and Plan Sponsor, acting for and on behalf of its group health plan ("Plan") purchased group dental benefits and/or vision benefits, and/or other ancillary insurance or benefit contracts (together hereinafter the "Benefits") from Delta Dental of Arizona and/or its affiliates whether acting as insurer, producer, or administrator ("DDAZ"). Certain of the Benefits may involve the exchange of Protected Health Information and Electronic Protected Health Information as defined in 45 C.F.R. § 160.103 ("PHI") with DDAZ as defined below. In order to facilitate the exchange of PHI (and non-PHI) in connection with those Benefits between DDAZ and the Plan, subject to any applicable federal and state privacy laws, Group and Plan Sponsor acting for and on behalf of its Plan hereby authorizes the disclosure, transmission, receipt and exchange of PHI by, between and among DDAZ and the Plan, the Plan's third-party administrator ("Plan Admin"), and its producer, broker and/or agent ("Broker") including with, through and over a benefit enrollment services platform ("Platform") utilized by Broker, Plan, Plan Admin, and DDAZ.

For any confidential and/or sensitive information that is not deemed PHI (such as employer record information that may be required for enrollment, disenrollment or eligibility purposes with respect to the Benefits) as well as the disclosure of limited categories of PHI that may be shared with Group and Plan Sponsor without an individual's authorization (such as Summary Health Information of the participants as defined in 45 C.F.R. § 164.504(a) for the purposes of underwriting, brokering, and obtaining premium bids for the purposes of quoting on or renewing Benefits, or for modifying, amending or terminating any of the Benefits), subject to any applicable federal and state privacy laws, Group and Plan Sponsor acting for and on behalf of its Plan hereby authorize the disclosure, transmission, receipt and exchange by, between and among DDAZ and the Plan, the Plan Admin, and Broker including with, through and over Platform utilized by Broker, Plan, Plan Admin, and DDAZ.

Additionally, Group and Plan Sponsor agree as follows:

Group and Plan Sponsor are responsible for compliance with relevant state/federal law if a breach of PHI occurs related to plan functions performed by Group and Plan Sponsor.

Group and Plan Sponsor agree that any request it makes for the disclosure of PHI will comply with the minimum necessary standard as set for at 45 C.F.R. 164.502(b) and 164.514(d) and that DDAZ has no obligation to make a separate determination of whether the information accessed or requested by Group and Plan Sponsor satisfies HIPAA's minimum necessary standard.

Group and Plan Sponsor agree that any request for DDAZ to make available claims data will be used by plan sponsor employees for plan administration functions consistent with 45 CFR 164.504(f)(2) and 164.314(b) and that DDAZ has no obligation to make a separate determination of whether the information accessed or requested by Group and Plan Sponsor qualifies as a plan administration function.

1. Designation of Broker and TPA

This Authorization is effective for the Plan, Plan Admin and Broker named on this form.

If the Broker listed on this form is, at any time, different from the broker listed on a Broker of Record form ("BOR form") properly filed with DDAZ, then Group and Plan Sponsor instruct DDAZ that Broker for purposes of this authorization will be the broker designated on the most current BOR form filed with DDAZ.

Should the Group and Plan Sponsor's designated Broker or third party administrator change, the Group and Plan Sponsor is required to update their authorization so that DDAZ may continue to share information.

Group Name: _____ DDAZ Group Number: _____

Designated Broker: _____ Broker NPN: _____

General Agency: _____ GA Broker NPN: _____

Designated Third Party Administrator: (Provide active/COBRA file feed vendor details below)

Active Feed TPA Company: _____

Address: _____

COBRA TPA Company: _____

Address: _____

2. Expiration of Authorization

This Authorization will expire immediately following the completion of DDAZ's services with respect to a terminated Benefit, however, it will continue with respect to any continuing services and Benefits provided by DDAZ. Additionally, this authorization will expire upon DDAZ's receipt of Group and Plan Sponsor's written request to terminate this Authorization.

3. Certification

Group and Plan Sponsor certifies that the employee signing below on behalf of the Group and Plan Sponsor has read and understands this Authorization form and has authority to sign and bind Group and Plan Sponsor to the terms set forth herein.

Group and Plan Sponsor Name: _____

Signature: _____

Name: _____

Title: _____

Date: _____