

## Personal Information Authorization Form

This form is used to advise Mercer Marketplace 365 of the person or persons you have chosen to have access to your personal health insurance and reimbursement account information.

**\*\*Please return the completed form to Mercer Marketplace\*\***

According to federal law, we must have your written permission (an “authorization”) to use or discuss your personal medical and health insurance information with another party. You may take back (“revoke”) your written permission at any time, except if Mercer Marketplace has already acted based on your permission.

Please complete the following information if you want to grant authorization for Mercer Marketplace 365 to speak to someone other than you. This authorization is good for up to one (1) calendar year from the date of signature.

*\* Please complete in black or blue ink*

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### Section 1: Beneficiary Information (person granting authorization)

Print Full Name: \_\_\_\_\_

Print Address: (Street address, City, State, & Zip Code)

\_\_\_\_\_  
\_\_\_\_\_

Telephone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Medicare #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

### Section 2: Authorized Individuals

Fill in the name(s) of the person(s) to whom you want to speak on your behalf with Mercer Marketplace.

1. Full name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

2. Full name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

3. Full name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

### Section 3: Authorized Information

I authorize Mercer Marketplace 365 to disclose the following information with the person(s) listed in Section 2 of this document: (*Check all that apply*)

- Information about insurance eligibility
- Information about plan enrollment (e.g. Medicare, Pre-65 Exchange, Dental, Vision, Ancillary, Short Term)
- Information about premiums and payment information
- Information about personal health history or status
- Information about reimbursement accounts (if applicable)

### Section 4: Period of Authorization

Check only one (1) box below indicating how long Mercer Marketplace 365 can use this authorization to disclose your personal information with the person(s) listed in Section 2 of this document.

- Disclose the information selected in Section 3 for one (1) year from the date of signature (Section 5)
- Disclose the information selected in Section 3 for a specified period of time only  
beginning: (mm/dd/yyyy) \_\_\_/\_\_\_/\_\_\_\_\_  
ending: (mm/dd/yyyy) \_\_\_/\_\_\_/\_\_\_\_\_

**Section 5: Beneficiary Signature**

I authorize Mercer Marketplace 365 to disclose the personal information listed above to the person(s) named on this form. I understand that my personal health information may be re-disclosed by the person(s) named on this form and may no longer be protected by law.

Beneficiary Signature: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Date (mm/dd/yyyy): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_


Check here if you are signing as the personal representative and complete the information below. Please attach the appropriate documentation (e.g., Durable Power of Attorney). This only applies if someone other than the beneficiary signed above.

Print the Personal Representative's Address (Street address, City, State & Zip Code)

\_\_\_\_\_  
\_\_\_\_\_

Telephone Number of Representative: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Personal Representative's Relationship to the Beneficiary: \_\_\_\_\_

 **Send the completed, signed authorization to:**

**Mail:**  
Mercer Marketplace  
P.O. Box 14401  
Des Moines, IA 50306-3401

**Email:**  
retiree.exchange@mercer.com

**Fax:**  
857-362-2999