RESET FORM

AUTHORIZED REPRESENTATIVE / HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) REQUEST

Voya Benefits Company, LLC
A member of the Voya® family of companies
Customer Service: PO Box 929, Manchester, NH 03105
Phone: 833-232-4673; Fax: 855-370-0670; Email: voyasupport@voya.benstrat.com

Health Account Solutions, including Health Savings Accounts, Flexible Spending Accounts, Commuter Benefits, Health Reimbursement Arrangements, and COBRA Administration offered by Voya Benefits Company, LLC (in New York, doing business as Voya BC, LLC). HSA custodial services provided by WEX Inc. For all other products, administration services provided in part by WEX Health, Inc.

This form is to document the designation of an Authorized Representative for a consumer. This form authorizes the release of medical information to the named representative(s). This authorization does not provide your Authorized Representative with any authority, either implied or direct, over any direct care decisions or account management. If you wish to set up a power of attorney or living will, discuss this with your attorney. We will not conduct benefit payments, enrollment or eligibility for benefits on the execution of this form.

STEP 1. CONSUMER INFORMATION

Consumer Name *(Required) (First)* _____ *(Last)* _____

Employer Name *(If sponsored by an employer plan.) (Required)* _____

Birth Date *(mm/dd/yyyy) (Required)* _____ Social Security Number (SSN) *(Required) (Last 4 digits only.)* _____

Daytime Phone *(Required)* (_____)_____ Email _____

Permanent Address *(Required)* _____

City _____ State _____ ZIP _____

STEP 2: AUTHORIZED REPRESENTATIVE INFORMATION

Authorized Representative Name *(Required)* _____ Last four digits of SSN *(Required)* _____

Authorized Representative Name _____ Last four digits of SSN _____

STEP 3: EXPIRATION & REVOCATION AND AUTHORIZED USE AND DISCLOSURE

I understand that due to HIPAA and other privacy regulations, Voya Financial will not disclose my personal health information to other parties without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named above for the purpose of assisting with, or facilitating, the coordination or payment of my health benefits. I also understand that if my Authorized Representative is not a healthcare provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws, and my Authorized Representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

I understand I have the right to revoke or end this authorization at any time. I understand that if I do not wish the person(s) named in Step 2 to remain my Authorized Representative, I must revoke this authorization in writing by giving written notice of my decision to Voya Financial. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released based upon this authorization before you actually receive my request to revoke it.

Further, I understand this authorization will terminate 12 months from the date of signature below (no authorization limit to designate an Authorized Representative on an HSA).

Consumer Signature *(Required)* _____ Date *(Required)* _____

Mail or fax completed form to:
Voya Financial, PO Box 929, Manchester, NH 03105; Fax: 855-370-0670.
Questions? Call Customer Service at 833-232-4673 (Live customer support 24x7).