CUSTOMER SERVICE CONSENT

Consent for NECA-IBEW Welfare Trust Fund, Customer Service Department to Use and Disclose my Individually Identifiable Health Information to designated representatives for the purpose of customer service inquiries.

I understand, as of April 14, 2003, NECA-IBEW Welfare Trust Fund and IBEW-NECA Benefits Administration Association can no longer share the individually identifiable health information that is maintained by NECA-IBEW Welfare Trust Fund with family members, friends or other designated representatives without written consent due to the privacy standards set forth in the Health Insurance Portability and Accountability Act (HIPAA). I also understand that Individual Identifiable Health Information may include, but is not limited to, health records, symptoms, examination and test results, diagnoses, treatment, treatment plans and billing information. I understand this consent is for the purposes of allowing the Customer Service Dept. at IBEW-NECA Benefits Administration Association to share my individually identifiable health information with family members and others I designate who make inquiries to Customer Service regarding but not limited to treatment, eligibility and payment of outstanding claims.

I have been provided a ***Notice of Privacy*** Policy that fully explains the uses and disclosures that IBEW-NECA Benefits Administration Association will make with respect to my individually identifiable health information without my consent. I understand this consent does not limit the uses and disclosures outlined in the *Notice*.

I understand that I have the right to revise those listed on this consent or terminate the consent. I further understand that IBEW-NECA Benefits Administration Association will share my individual identifiable health information with only those family members listed on this consent and should I terminate this consent, IBEW-NECA Benefits Administration Association will no longer be able to share my individual identifiable health information with family members. I also understand that terminating this consent will not affect the paying of my outstanding claims.

Family Members

Participant:_____**SS#**_____

Spouse:_____

Dependent:_____**Birthdate:**_____

Dependent:_____**Birthdate:**_____

Dependent:_____**Birthdate:**_____

Dependent:_____**Birthdate:**_____

Dependent:_____**Birthdate:**_____

Designated family members who may receive individual identifiable health information from IBEW-NECA Benefits Administration Association Customer Service Dept. on all those listed on other side.

Participant:_____

Spouse:_____

Others:_____

_____

_____

I understand that even with this consent I may not receive certain information on my dependents, which is prohibited by federal or state law. I also understand by signing this consent I hereby certify that I have complied with all applicable state law with respect to obtaining this consent. I acknowledge that NECA-IBEW Trust Fund is relying on this certification by me.

I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that IBEW-NECA Benefits Administration Association has already taken action in reliance on my earlier effective consent.

Participant's Signature **Signature of Witness**

_____ _____

Date_____

Spouse's Signature **Signature of Witness**

_____ _____

Date_____

Emancipated* Dependent's Signature **Signature of Witness**

_____ _____

Date_____

Emancipated* Dependent's Signature **Signature of Witness**

_____ _____

Date_____

Emancipated* Dependent's Signature **Signature of Witness**

_____ _____

Date_____

* Emancipated shall mean for the purpose of this consent, of legal age as defined in that state of residence.