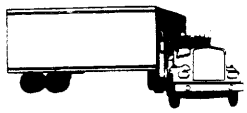

LOCAL

ROAD CARRIERS **707** WELFARE AND PENSION FUNDS

14 FRONT STREET • HEMPSTEAD, N.Y. 11550-3602
Phone: (516) 486-7100 • Fax: (516) 486-7375

HIPAA AUTHORIZATION FORM

PRINT NAME: _____ **SSN:**_____

The Health Insurance Portability and Accountability Act ("HIPAA") privacy regulations, which provide you with certain rights related to your protected health information ("PHI"), became effective on April 14, 2003. PHI is defined by HIPAA, but generally includes your personal health information. For this Authorization, PHI means claims detail, claims status reports, payment records, Explanation of Benefits forms, and coordination of benefits information. In general, these privacy regulations prohibit the Road Carriers Local 707 Welfare Fund (the "Fund") from disclosing your PHI without your permission. For example, except in certain circumstances, the Fund may not disclose your health information to your spouse or adult dependent, or disclose their PHI to you (although either parent or a legal guardian usually may have access to a minor child's PHI without the minor's authorization). The Fund also may not disclose your PHI to your union representative without your permission, even if he or she is assisting you with a benefits issue.

You may, however, authorize the Fund to disclose your PHI to a family member, union representative, or other person by completing this Authorization Form. This is your choice. You do not have to share your PHI with a family member, union representative, or any other person and/or you may limit the information provided (by noting such limitations on this form). The Fund does not condition your treatment, payment, enrollment, or eligibility for benefits on whether you agree to sign this Authorization. Once PHI is disclosed under this Authorization, the federal privacy regulations may no longer apply to your disclosed PHI, and the Fund is not responsible for preventing individual(s) to whom your PHI is disclosed from re-disclosing it.

Your authorization allows your PHI to be disclosed to the individual(s) named below in order to assist you with obtaining necessary medical care, filing health care claims, checking on the status of your health care claims, and/or working with the Fund to resolve any other issues related to health benefits.

☐ **FAMILY MEMBER: I authorize the Fund to disclose my PHI to the following family member:**

_____ _____
Name and SSN Relation

☐ **UNION REPRESENTATIVE: I authorize the Fund to disclose my PHI to my union representative (including Business Agent, Union Steward, and/ or Union Official):**

_____ _____
Name of Union Representative Title

☐ **OTHER PERSON: I authorize the Fund to disclose my PHI to:**

_____ _____
Name Relation

This authorization will expire at the end of your enrollment in the Fund or on the following date or event: _____

Revocation: You may revoke this Authorization at any time by sending a letter or revocation form to: David B. Stewart, Fund Manager/Privacy Officer, Road Carriers Local 707 Welfare Fund, 14 Front Street, Hempstead, NY 11550. The revocation will take effect on the date that it is received by the Privacy Officer, but any revocation will be effective only to the extent that the Fund has not already disclosed your PHI based on this Authorization.

_____ _____
Signature Date

If you are the personal representative of a participant (parent, power of attorney, etc.), please complete this box.

_____
Name of personal representative

_____ _____
Signature of personal representative (if applicable) *Date*

_____
Description of personal representative's authority to act for the individual (if applicable)

If the Fund seeks this Authorization, it must give you a signed copy.