Colleague Authorization to Use and Disclose Protected Health Information

This form authorizes TriNet, in its capacity as administrator of a benefits plan sponsored by TriNet* to use or disclose your protected health information ("PHI") as specified in Sections 2, 3 and 4 below. This authorization is purely voluntary. However, please understand that, if TriNet does not have a valid, completed and signed authorization on file for you, TriNet will **not** be able to discuss your PHI with anyone other than you. Signing or not signing this form will not affect any reimbursement, enrollment, eligibility or other decisions made by TriNet. Please keep a copy of this form in a safe place, for your records. A copy of this authorization can be requested by contacting the Corporate Benefits team via email at Colleaguebenefitswellness@TriNet.com.

Please return your completed and signed authorization form to:

Email: Colleaguebenefitswellness@TriNet.com (You should send and attach the signed form from your TriNet email or request a private link to send from your personal email.)	OR	Plan Administrator Attn: Corporate Benefits TriNet One Park Place, Suite 600 Dublin, CA 94568

You may revoke this authorization at any time by submitting your written, signed revocation to TriNet at the email or mailing address above.

You must complete Sections 1-6. If you are a personal representative acting on behalf of the covered person listed in Section 1 below, you are also required to complete Section 7 and submit supporting documentation. If you need help completing this form, please contact the Corporate Benefits team via email at Corporate-Benefits@TriNet.com.

SECTION 1: TELL US WHO YOU ARE (Please print and complete all information.)

Full Name:	Date of Birth:
Address:	Phone Number:
City, State, Zip:	TriNet Employee ID# or Last Four Digits of SSN ONLY:
Email Address:	

- TriNet-sponsored plans include: TriNet HR III, Inc. Colleague Benefits Plan and TriNet USA, Inc. Colleague Benefits Plan.

SECTION 2: WHAT IS THE PURPOSE OF THIS AUTHORIZATION? (Please check all that apply.)

☐ To authorize the identified persons or organizations to discuss with TriNet the PHI indicated for purposes of plan claims or eligibility assistance.

☐ To authorize the identified persons or organizations to inspect or obtain copies of the PHI for purpose of plan claims or eligibility assistance.

SECTION 3: WHO IS AUTHORIZED TO RECEIVE OR DISCUSS YOUR PHI? (Please attach additional sheets, if necessary, containing the below information.)

Name/Organization	Relationship to You	Last Four Digits of SSN or Zip Code if an Organization

SECTION 4: WHAT PHI DO YOU AUTHORIZE US TO DISCLOSE? (Please check all that apply. Only PHI that is minimally necessary to help resolve the problem/issue will be disclosed.)

☐ Claim information regarding your TriNet-sponsored flexible spending account (FSA). (**Please note:** TriNet is not an insurance company. It does not process any medical, dental or vision claims. If you have questions about such claims, you must contact your insurance carrier directly.)

☐ General benefits information (e.g., enrollment, eligibility, status of COBRA payments, address, date of birth)

SECTION 5: WHEN DO YOU WANT THIS AUTHORIZATION TO EXPIRE? (Please check only one.)*

☐ On the following date, provided it is not affirmatively cancelled sooner: _____

☐ Until I send TriNet a letter, signed by me or my authorized representative, canceling my authorization.

*Regardless of the selection made above, this authorization will expire upon the termination of your participation under the plan.

SECTION 6: INITIALED ACKNOWLEDGEMENTS AND SIGNATURE *Please note: electronic initials and signature can only be accepted if this PHI form is submitted, by the person in Section 1, via a validated email address listed on file.*

_____ Initials Required — I understand that, if the person/entity authorized to receive my PHI is not a health plan, health care provider, or other covered entity as described by the HIPAA Privacy Rule, the released information may be re-disclosed and may no longer be protected by federal privacy laws, rules and regulations.

_____ Initials Required — I understand that the information disclosed may include mental health information, alcohol or substance abuse information or both.

_____ Initials Required — I understand that I am not required to sign this form, but if I do not sign this form, it will not be considered valid by TriNet. I understand that I am not required to sign this form to receive any benefits under the plan, to be eligible for such benefits, or to receive payment/reimbursement for such benefits.

_____ Initials Required — I understand that I may revoke this authorization at any time by notifying TriNet in a signed writing. If I do revoke this authorization, I understand that my revocation will have no effect on actions taken Initials Required by TriNet in accordance with this authorization before TriNet received my revocation.

By submitting this form, I hereby request the plan to release my PHI, as provided above. I agree that this information is true and correct. I sign this authorization under penalties of perjury and attest that TriNet may rely on my signature and the contents of this authorization.

_____ Signature

_____ Date

SECTION 7: PERSONAL REPRESENTATIVE (If you are the person listed in Section 1, you may skip Section 7.) If you are acting on behalf of the person listed in Section 1, you are called the Personal Representative and you must complete this section.

Please include a copy of one of the following documents as proof of legal representation:

_____ Valid health care proxy

_____ Certificate of Guardianship issued by the appropriate court

_____ Letter of incapacity from a licensed physician

If the person listed in Section 1 is deceased, please submit a copy of one of the following:

_____ Administrator's Certificate

_____ Executor's Certificate

_____ Surviving Spouse's Certificate, if applicable

By submitting this form, I represent that I am the Personal Representative of the Participant named above and that I am not prohibited by Court Order from requesting amendment to the requested information. I agree that this information is true and correct. I sign this authorization under penalties of perjury and attest that TriNet may rely on my signature and the contents of this authorization.

_____

Printed Name of Personal Representative

_____ _____

Signature of Personal Representative Date

TRINET USE ONLY

Form Received By: _____

Date: _____