State of Washington
Navia Benefit Solutions Authorization for Release of Information

Important information about your rights

- I may revoke this authorization at any time prior to its expiration by notifying Navia Benefit Solutions in writing. The revocation will not have any effect on any actions that Navia Benefit Solutions took before receiving the revocation.
- I may see and copy the information described on this form, if requested.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity. I have the right to seek assurances from the below named persons/organizations authorized to receive the information that they will not re-disclose the information to any other party without my further authorization.
- If the Covered Entity (employer) is requesting the authorization, then the participant must receive a copy of this authorization.

Information regarding this Authorization for Release of Information form:

I have read and understood the following statements about my rights. I hereby authorize the use or disclosure of my individually identifiable health information as described below. (Please sign and date on the back of this form.)

Participant Name (print): ____

SSN (or Employee ID if higher education): ____

1. Please provide a specific description of the information you would like to have used or disclosed.

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2. Name the person or class of persons authorized to make the requested use or disclosure (for example, a specific customer service representative at Navia Benefit Solutions or name Navia Benefit Solutions as a class).

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3. Name the person or class of persons to whom Navia Benefit Solutions may make the disclosure (for example, a specific Human Resource (HR) person or the HR unit as a class of persons at a specific agency).

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4. Describe the purpose for the requested disclosure (if you elect not to provide a statement of purpose you can provide a general statement such as "at the request of the individual").

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Email: customerservice@naviabenefits.com
Fax: (425) 451-7002 or toll-free (866) 535-9227
Customer Service Line: (425) 452-3500 or (800) 669-3539

5. Describe the expiration date or expiration event for this Authorization for Release of Information (for example, a specific date or event such as the end of the plan year, or once a specific claim is resolved, etc.)

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6. *For Participant's Representative, please provide a description of authority to act on behalf of the participant.* Description of Authority (if applicable).

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Signature:

Please sign and date prior to returning this form to Navia Benefit Solutions.
Email: customerservice@naviabenefits.com
Fax: (425) 451-7002 or toll-free (866) 535-9227
Customer Service Line: (425) 452-3500 or (800) 669-3539

I understand that this authorization is voluntary. I may refuse to sign it and I may revoke it at any time in writing to Navia Benefit Solutions.

Participant Signature: _______________________________Date: ________________