Authorization for Enrollment or Eligibility

Instruction to Applicants

This form authorizes disclosure of the medical information described below of the primary applicant and (if applicable) members of the primary applicant's family to Blue Cross Blue Shield of North Dakota (BCBSND) for use in pre-enrollment underwriting or risk-rating or to determine eligibility for enrollment in or benefits under a health plan.

Each individual age 12 and over, for whom the primary applicant is applying for health plan coverage, must sign this authorization. A parent may sign this authorization on behalf of a child under age 12. **If a legal representative (e.g. Power of Attorney, Legal Guardian, etc.) signs this authorization on behalf of an individual, include a copy of the power of attorney or other relevant document evidencing the authority to represent the individual.**

By signing this form, I authorize the use and disclosure of the medical information described below for pre-enrollment underwriting or risk-rating of health insurance coverage or to determine eligibility for enrollment or benefits under a health plan. I understand that this authorization is a condition of enrollment in or eligibility for benefits under a health plan for myself and (if applicable) my spouse and my dependent children. If I or (if applicable) my spouse or my dependent children decline to sign this authorization, enrollment in a health plan may be denied.

I hereby authorize _____
who has advised, treated, attended or provided care or service to me or my dependent children or is in possession of any medical information and records (e.g., chart notes, lab/path reports, radiology reports) regarding me or my dependent children, to furnish such medical information and records covering the last 5 years to Blue Cross Blue Shield of North Dakota (BCBSND).

I understand that this authorization applies to use and disclosure of medical information and records that may relate to sexually transmitted disease, use of contraceptives, prenatal care, termination of pregnancy, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), treatment for alcohol or drug abuse, and receipt of behavioral or mental health services.

I understand that if the recipient of this medical information is not a health care provider or health plan covered by federal privacy regulations, this medical information may be re-disclosed and no longer protected by these federal regulations. BCBSND is subject to federal privacy regulations and will not re-disclose this medical information except as allowed by law.

I understand that I have the right to revoke or end this authorization at any time. I understand that in order to revoke this authorization I must do so in writing to BCBSND. I understand that my revocation of this authorization will not affect any action that has been taken, or any medical information that has already been used or disclosed, based upon this authorization before BCBSND actually received my revocation.

This authorization will remain in effect for the earlier of 12 months from the date of signature or the earlier date entered here: _____.

I have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am authorizing the use and/or disclosure of medical information as described in this form.
I agree that a copy of this Authorization shall be as valid as the original.

Personal Information

Name	Birth Date (MM/DD/YYYY)
Maiden Name	Date (MM/DD/YYYY)
Signature	
(If Applicable) Legal Representative Signature	Relationship