



175 Scott Swamp Road
Farmington, CT 06034
1-800-251-7722

BROKER AUTHORIZATION FORM

Note: This authorization form is not required as part of your application for individual coverage. By completing this form, you are giving permission for your broker to access your personal health information for purposes of checking the status of your application. All applicants over age 18 may sign the same copy of this form. However, if you prefer, each applicant over age 18 may sign his or her own copy.

I, _____ hereby authorize ConnectiCare and its affiliates, its employees and agents (collectively “ConnectiCare”), to release to _____ **Creative Health Insurance**
[Insert full name of broker/agency] my and/or my dependents’ (those who are under the age of 18 and applying for coverage) personal health information maintained by ConnectiCare (e.g., information relating to the diagnosis, treatment, claims information, and health care services provided or to be provided and which includes either name, address, social security number, or Member ID number) except the following information:

[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY] for the purpose of assisting me in my application for individual insurance coverage with ConnectiCare.

I understand that any personal health information or other information released to the broker/agency identified above may be subject to redisclosure by such broker/agency and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative’s signature below and shall expire the earlier of _____ [INSERT DATE/EVENT UPON WHICH THIS AUTHORIZATION EXPIRES] or the date upon which ConnectiCare has made a determination with respect to my application for coverage. I understand that I have a right to revoke this authorization by providing written notice to ConnectiCare. However, this authorization may not be revoked if ConnectiCare, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment in an individual plan.

ConnectiCare

Broker Authorization Form

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Name of Applicant: _____

Signature of Applicant: _____

Date: _____

Name of Applicant: _____

Signature of Applicant: _____

Date: _____

Name of Applicant: _____

Signature of Applicant: _____

Date: _____

If applicable, Legal Representatives (including parent/guardian of a minor child) sign below:

By signing this form, I represent that I am the legal representative of the Applicant identified below and will provide written proof (e.g., Power of Attorney, guardianship papers, etc.) that I am legally authorized to act on the Applicant's behalf with respect to this authorization form.

Name of Applicant: _____

Name of Legal Representative: _____

Signature of Legal Representative: _____

Relationship to Applicant: _____

Date: _____