AutoNation

BENEFIT INQUIRY & HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION FROM AN AUTONATION PLAN

In order to track the type of inquiries and turnaround response time, **please complete the following form and email to: Vanessa Mainster at MainsterV@autonation.com**

In order to maintain a log please do not email to anyone else in the Benefits Department.

Please **complete section A** regarding your benefit inquiry and **only complete section B** if your inquiry is in regard to a medical, prescription drug, dental, vision or Flexible Spending account claim, disability leave, personal medical information or medical information regarding a dependent.

SECTION A. BENEFIT INQUIRY

1. Did you contact The Benefit Connection first to try to resolve your inquiry? If yes, date called _____/_____/_____. If no, please call The Benefit Connection first at 1-877-550-BENE (2363).

2. If step 1 is answered "yes" please complete the following:

PLEASE PRINT EMPLOYEE'S NAME (LAST, FIRST):	**EMPLOYEE'S SOCIAL SECURITY NUMBER:**
_____,_____	_____-_____-_____ _____ _____ _____

Nature of Inquiry

Completed By:

_____,_____
Last Name First Name

Phone Number: _____

Date: _____/_____/_____
Month Day Year

Email: _____

This request is
(Place an X in the box that applies)

- ☐ Urgent (48 hour turn around time required)
- ☐ Immediate (5-7 business days)
- ☐ Regular (7-10 business days)

SECTION B. HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION FROM AN AUTONATION PLAN

I. Authorization: I hereby authorize the (Place an X next to the box that applies – one or more of the following):

_____ **AutoNation Medical Benefits Plan/AutoNation Medical Wraparound Medical Plan**

_____ **AutoNation Dental Benefits Plan**

_____ **AutoNation Flexible Spending Accounts Plan**

_____ **AutoNation Vision Benefits Plan**

(the "Plan") to disclose my health information as follows: (if you need more space for any item, please use the back of the form)

1. Information to be Disclosed:

2. Person(s) to whom the Plan May Disclose the Above Information (list the specific person(s) or class of persons):
Vanessa Mainster

3. Purpose of Use or Disclosure (either list purpose or state "at the request of individual", if applicable):

4. Expiration of Authorization (must be specific date, not open ended such as "until resolved" or "indefinitely"):

_____/_____/_____
Month Day Year

I understand that:

- I have the right to revoke this Authorization at any time for future disclosures the Plan may make, unless the Plan has taken action in reliance upon this Authorization. I must revoke this Authorization by completing and executing Section II to this Authorization and submitting it to the Plan's Office of Privacy Governance, 200 Southwest 1st Avenue, 14th Floor, Fort Lauderdale, FL 33301. I understand that the revocation will not be effective until received by the Plan. I also understand that a revocation is not needed for the Expiration Date in Paragraph 4 above to be effective.
- This authorization does not encompass or include the use or disclosure of any psychotherapy notes, unless specifically stated.
- The Plan may not condition my treatment, payment, enrollment, or eligibility for benefits upon whether I sign this Authorization.
- Once my information has been disclosed, as permitted under this Authorization, it no longer will be protected under the federal privacy regulations of the Health Insurance Portability and Accountability Act ("HIPAA"), so there is a possibility that the party to whom my information is being disclosed may re-disclose the information without my permission.
- The Plan will not receive any direct or indirect remuneration from a third party as a result of this use or disclosure.

Signature:	**Date:**
_____	_____/_____/_____ Month Day Year

* If this Authorization is being signed by the individual's personal representative, describe below your authority to act on the individual's behalf. If there is a legal document that evidences your authority to act (power of attorney, court order, etc.), you must attach a copy of such document when you submit this Authorization. If the documentation is not presented, the Plan will not proceed until it is presented to the Plan.

II. Revocation: I hereby revoke the Authorization granted in Section I above. I understand that this revocation will only become effective when the Plan receives it.

Signature:	**Date:**
_____	_____/_____/_____ Month Day Year