UFCWTRUST
Working For Your Benefit

UFCW & Employers Trust, LLC
Health Reimbursement Account (HRA)
Disclosure and Authorization for Kaiser HMO Participants

DISCLOSURE: As a participant in the Fund who has enrolled in the Wellness Program (HCP), you have access to a Health Reimbursement Account ("HRA"). You may use funds in your HRA to pay or be reimbursed for your out-of-pocket expenses. Details concerning your HRA benefit are described in the program materials you will receive or have received from the Fund. In order for the Fund to determine the amounts to be paid or reimbursed to you from your HRA for out of pocket expenses incurred in your Kaiser HMO plan, and for other reporting and administrative purposes, Kaiser will need to provide the Trust Fund Office your demographic information (name, social security number, date of birth, and/or other identifying and contact information) and your claims information (collectively "protected health information" or "PHI"). Specifically, your Kaiser HMO plan (the Kaiser Foundation Health Plan, Inc., Northern California Region) will share information about you with the Trust Fund Office for purposes of administering the HRA feature, but only if you authorize your Kaiser HMO plan to share such information.

AUTHORIZATION: I understand that in order to be eligible for the Fund's HRA reimbursements while covered under the Kaiser HMO plan, my PHI will be used and disclosed as described above by my Kaiser HMO plan, and the Trust Fund Office.

CHECK ONE:

☐ ***YES, I want to share my information for purposes of enrolling in, and administration of, the Kaiser Permanente HRA plan.***

☐ ***NO, I decline to share my information.***

I understand that my Kaiser HMO plan will not condition treatment, payment, enrollment, or eligibility for health coverage on my providing or refusing to provide this authorization. I understand that enrolling in the Kaiser Permanente HRA is not a requirement for me to enroll in the Kaiser HMO option under the Fund's Plan.

DURATION: This authorization shall become effective immediately and shall remain in effect for a year from the date of your signature**,** except in California (where this authorization is valid until **12/31/2024**.)

REVOCATION: I understand that I may revoke this authorization in writing at any time by contacting the Trust Fund Office and requesting a revocation form, or submitting my request through the ufcwtrust.com website behind the login. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Participant Signature: _____ **Date:** _____

I am over 18, and I am authorized to sign this authorization on my own behalf

First Name: _____ **Last Name:** _____ **Last 4 of SSN:** _____

Important: *Member Information (if different than above):*

Member First Name: _____ **Member Last Name:** _____ **Last 4 of Member SSN:** _____

You have the right to receive a copy of this authorization.

Mail to: PO Box 4100, Concord, CA 94524-4100 -OR- Fax to: (925) 746-7549

If you have questions about this notice, please contact Health & Welfare Services, Monday – Friday, at (800) 552-2400