6 North Park Drive, Suite 310
Hunt Valley, MD 21030
Phone: (410) 832-1300 1 (800) 638.6085
www.gbshealthcare.net

EMPLOYEE Simplified Underwriting RX Authorization (IRX)

Please choose from the following: ☐ New Applicant ☐ Information Update ☐ COBRA Applicant

Employee Name:		Employer Name:	
Home Phone:		Work Phone:	
Address:		City: State:	ZIP Code:
Email Address:		Marital Status:	
Date of Hire:	Currently Full Time? ☐Yes ☐No	Hours Worked per Week:	Salary:
Occupation:	Division:	Is Spouse Employed? ☐Yes ☐No	

In order to allow decisions to be made regarding eligibility, underwriting and premium risk rating relative to the employer's self-funded health plan and excess loss coverage, I hereby authorize any insurers, reinsurers and their agents to obtain, receive and use my personal information that is contained on any applications or enrollment forms that I have completed within the last 90 days.

I also hereby authorize any physician, medical practitioner, hospital, clinic, Veterans administrations facility, other medical or medically related facility, insurance or reinsurance company, pharmacy, pharmacy benefit manager, health plan, or Consumer Reporting Agency, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me or my minor children and other non-medical information of me and my minor children, to release to the claims or third party administrator, any other excess loss insurance carrier designated by the Plan, or its legal representative, any and all such information as required for determination of eligibility for benefits. I understand that I may request a copy of this authorization at any time. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I agree that a photographic copy of this authorization shall be as valid as the original, and that this authorization shall be valid for 2 ½ years from the date shown below. I understand the information obtained by use of this authorization may be used by the Plan Sponsor, claims or third party administrator, and any excess loss insurance carrier designated by the Plan to determine my eligibility for health coverage, and eligibility for benefits under an existing plan. Any information obtained will not be released to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my enrollment for the coverage, for any claim, for medical management purposes, or as may be otherwise lawfully required or as I may further authorize. I also understand that I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. Should I refuse to sign this authorization, I understand it may affect my enrollment in the benefit plan. All pages must be attached and complete, including this authorization for the application to be considered complete. Incomplete applications may be rejected.

Employee Signature X ____ Printed Name____ Date ____________________

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant:____

Spouse Signature X ____ Printed Name____ Date ___________________

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant:____

Dependent Child Signature X ___________________________________ Printed Name____ Date ___________________
(18+years of age)

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant:____

Dependent Child Signature X ___________________________________ Printed Name____ Date ___________________
(18+years of age)

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant:____

Dependent Child Signature X ___________________________________ Printed Name____ Date ___________________
(18+years of age)

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant:____