

**REQUEST FOR THIRD PARTY EXPLANATION OF BENEFITS
AND AUTHORIZATION TO RELEASE
GROUP HEALTH INFORMATION**

Attention: Wellmark, Inc.

Acting as Plan Sponsor or Administrator of the _____ Health Plan, Wellmark is hereby directed to disclose third party explanation of benefits (EOB's) for participants in the Health Plan for the purpose of administering a:

- Fully self-funded group health plan
- Partially self-funded reimbursement plan
- Medical reimbursement or flexible spending plan

The third party EOB's are to be provided to the:

- Group health plan address (for a self-administered plan)
- Third party administer indicated below

Employee Benefit Systems (EBS)

(Third Party Administrator Name)

Joni Clover

(Attention)

214 N Main Street – PO Box 1053

(Street Address)

Burlington, IA 52601

(City State Zip)

We acknowledge that the Protected Health Information to be disclosed is confidential. Wellmark may rely on our direction to be the minimum necessary for the intended purpose of the disclosure.

If the Protected Health Information is to be provided to a third party, the plan sponsor or plan administrator certifies we have received satisfactory assurance from the above named Business Associate to safeguard and not further use or disclose the Protected Health Information.

Wellmark is entitled to rely upon this letter and its directions as authorization to release this information until we revoke this letter in writing to you.

Signed,

Plan Sponsor or Authorized Representative for Group Health Plan

Title

Date