HR SIMPLIFIED

Dependent Debit Card and Release of Information Form

Additional Debit Card(s)

Please complete your dependent information below and check the Card box. The additional card(s) will be mailed in approximately 14 business days. There is no fee for these additional cards. **Debit cards cannot be ordered for dependents under the age of 18.**

Release of Information (ROI):

In the interest if protecting the privacy of the health information of our participants, HR Simplified does not provide identifiable health information to persons other than the plan participant, i.e. spouse, unless you direct us to do so. If you would like information relating to you or your plan released to any other person(s) please provide their information below, check the ROI box and sign and date this form.

Fill out the form below and fax or mail to HR Simplified.

FAX: 877-723-0146 **MAIL:** HR Simplified, Inc., PO Box 56021, Boston, MA 02205

Employer Name: _____

Employee Name: _____

Employee ID or Social Security Number: _____

Dependent Info:

Spouse Name: _____ ☐ Card ☐ ROI*

Social Security Number: _____ Date of Birth: _____

Address (if different than Employee): _____
STREET CITY STATE ZIP

Dependent Name: _____ ☐ Card ☐ ROI*

Social Security Number: _____ Date of Birth: _____

Address (if different than Employee): _____
STREET CITY STATE ZIP

Dependent Name: _____ ☐ Card ☐ ROI*

Social Security Number: _____ Date of Birth: _____

Address (if different than Employee): _____
STREET CITY STATE ZIP

*I hereby authorize the use or disclosure of my individually identifiable health information as described in this authorization. *I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation request in writing to the entity providing this information.* I have read and understood the following statements about my rights: **1)** I may see and copy the information described on this form if I ask for it. **2)** I am not required to sign this form to receive my health care benefits. **3)** The information that is used or disclosed pursuant to this authorization may be disclosed again by the receiving entity. I have the right to seek assurances from the above named person/organizations authorized to receive the information that they will not disclose again the information to any other party without my further authorization.

_____ _____
SIGNATURE DATE