



175 Scott Swamp Road  
Farmington, CT 06034  
1-800-251-7722

## BROKER AUTHORIZATION FORM

**Note: This authorization form is not required as part of your application for individual coverage. By completing this form, you are giving permission for your broker to access your personal health information for purposes of checking the status of your application.**

By signing below, I hereby authorize ConnectiCare, Inc., its affiliates, employees and agents (collectively “ConnectiCare”), to release to \_\_\_\_\_ [insert full name of broker/agency] my and/or my dependents’ (those who are under the age of 18 and applying for coverage) personal health information maintained by ConnectiCare (e.g., information relating to the diagnosis, treatment, claims information, and health care services provided or to be provided and which identifies either name, address, social security number or Member ID number) for the purpose of assisting me in my application for individual insurance coverage with ConnectiCare.

I understand that ConnectiCare cannot exclude any particular personal information, and that any personal information that is received by ConnectiCare in connection with my application may be accessible to the broker/agency identified above.

I understand that any personal health information or other information released to the broker/agency identified above may be subject to redisclosure by such broker/agency and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative’s signature below and shall expire one year after the date upon which ConnectiCare makes a determination with respect to my application for coverage. I understand that I have a right to revoke this authorization by providing written notice to ConnectiCare. However, this authorization may not be revoked if ConnectiCare, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

ConnectiCare

Broker Authorization Form

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Name of Applicant: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Applicant: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Applicant: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

If applicable, Legal Representatives sign below:

*By signing this form, I represent that I am the legal representative of the Applicant identified below and will provide written proof (e.g., Power of Attorney) that I am legally authorized to act on the Applicant's behalf with respect to this authorization form.*

Name of Applicant: \_\_\_\_\_

Name of Legal Representative: \_\_\_\_\_

Signature of Legal Representative: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Date: \_\_\_\_\_