

# WEB AUTHORIZATION FORM



**Employer Group Name:** \_\_\_\_\_  
**(“Employer Group”)**, hereby authorizes and requests that Tufts Health Plan provide, to the individual designated below, electronic access to information submitted to Tufts Health Plan by the above named Employer Group related to health care coverage provided to members covered under Employer Group, and allow this individual to perform certain functions pertaining to Employer Group on the Tufts Health Plan website, including but not limited to accessing enrollment and eligibility information and performing website functions on Employer Group’s behalf. Pursuant to this Web Authorization Form, Tufts Health Plan will grant access to the Senior Access Administrator designated below and to Access Administrators and Authorized Users designated by the Senior Access Administrator or Employer Group. Tufts Health Plan may provide these designated individuals with access to information relating to the Employer Group’s past groups, current groups and any future groups as long as this Web Authorization Form is in effect. The Senior Access Administrator will be responsible for communicating to Tufts Health Plan the identity of all additional Access Administrators and Authorized Users whom Employer Group authorizes to access Employer Group enrollment and eligibility information and perform website functions on behalf of the Employer Group. Employer Group hereby grants that authority and responsibility to the Senior Access Administrator

designated below. Employer Group understands that it is responsible for compliance with all applicable federal and state requirements concerning the confidentiality of health care information, and that Employer Group retains ultimate responsibility for the actions and use of that information by those designated pursuant to this Web Authorization Form. Employer Group agrees to take certain precautions, comply with certain practices, implement certain procedures and enter into any other agreements or documents required by HIPAA and other applicable law for the purposes of guarding data integrity and safeguarding the confidentiality of health care information. Employer Group understands that Tufts Health Plan will require that any person Employer Group designates as a Senior Access Administrator, Access Administrator or Authorized User must accept certain Terms of Use agreeing to comply with, among other things, HIPAA and other requirements concerning the confidentiality and security of private health care information. Employer Group further understands that it is Employer Group’s responsibility to inform Tufts Health Plan of any changes to the Senior Access Administrator designation below and that Tufts Health Plan or Employer Group can terminate this Web Authorization Form at any time upon prior written notice.

The date of signature will be deemed the effective date of this Web Authorization Form unless otherwise stated.

## AUTHORIZATION FORM SIGNATURE REQUIREMENTS:

For the purposes of website registration and signature requirements for this Web Authorization Form, the individual signing this document must be an individual empowered by that entity to bind the entity in this legal agreement. (eg: CEO, CFO, General Counsel, President, VP, Partner, Treasurer) If you have submitted an on-line registration request, the Signatory identified below must also be the person identified as the Signatory on your on-line registration application.

I certify that I am an authorized representative empowered to bind Employer Group in this legal document. I have read, understand, and agree to the terms of this Web Authorization Form:  _____ Print Name*  _____ Print Title*  _____ Signature*  _____ Date*  _____ Name of Employer Group*  _____ E-Mail Address*	Senior Access Administrator: Must be an officer or employee of your company. The Senior Access Administrator cannot be a broker.  _____ Print Name*  _____ Print Title*  _____ Phone*  _____ E-Mail Address*  *Required Fields
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For Internal Use Only:  
Group ID# \_\_\_\_\_ #eligibles \_\_\_\_\_ Sales Rep Name \_\_\_\_\_ Sales Rep Signature \_\_\_\_\_