WEBT
Protected Health Information (PHI)
Authorization Form

Group Name: _____

Date: _____

NAME AND TITLE OF PERSON(S) AUTHORIZED TO RECEIVE PROTECTED HEALTH INFORMATION:

Name	Title	Access To:
Willis Towers Watson	Consultant	All

The individuals noted above have been designated by the Group to receive the Participant's Protected Health Information relating to payment under health care operations of, or other matters pertaining to the Benefit Plan in the ordinary course of business. These indentified individuals will have access to the Participant's Protected Health Information only to perform the plan administrative functions the Group provides to the Benefit Plan. Such individuals will be subject to disciplinary action for any use or disclosure of the Participant's Protected Health Information in breach or in violation of, or noncompliance with, the privacy provisions of the Benefit Plan. The Group shall promptly report any such breach, violation, or noncompliance to Willis Towers Watson; will cooperate with Willis Towers Watson to correct the breach, violation and noncompliance to impose appropriate disciplinary action on each employee or other workforce person causing the breach, violation or noncompliance; and will mitigate any harmful effect of the breach, violation, or noncompliance on any Participant whose privacy may have been compromised.

The Group will notify Willis Towers Watson, in advance, of any change in the name or title of the employees authorized to receive Participant's Protected Health Information.

DELETIONS:

The individuals noted below are no longer authorized to receive Protected Health Information.

Name	Title

_____ _____

Authorized Signature by Group Official Title