AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

This form authorizes TriNet, in its capacity as administrator of the "TriNet Group, Inc. Section 125, Section 129, and Flexible Spending Account Plan" (the "Plan"), to use and/or disclose your protected health information ("PHI") as specified in Sections 2, 3 and 4 below. This authorization is purely voluntary. However, please understand that, if TriNet does not have a valid, completed and signed authorization on file for you, TriNet will **not** be able to discuss your PHI with anyone but you. Signing or not signing this form will not affect any reimbursement, enrollment, eligibility, or other decisions made by TriNet. Please keep a copy of this form in a safe place, for your records. However, a copy of this Authorization can be requested by contacting TriNet's Employee Solution Center at 800-638-0461.

Please return your completed and signed authorization form to:

Email PHI@trinet.com (You must attach your signed form to your email) OR	Fax (941) 744-8021 OR	Plan Administrator Attn: Benefits Compliance TriNet 9000 Town Center Parkway Bradenton, FL 34202

You may revoke this authorization at any time by submitting your written, signed revocation to TriNet at the email address, fax number, or mailing address above.

You must complete Sections 1-6. If you are a personal representative acting on behalf of the covered person listed in Section 1 below, you are also required to complete Section 7 and submit supporting documentation. If you need help completing this form, please contact TriNet's Employee Solution Center at 800-638-0461.

You must complete Sections 1-6. If you are a personal representative acting on behalf of the covered person listed in Section 1 below, you are also required to complete Section 7 and submit supporting documentation. If you need help completing this form, please contact TriNet's Employee Solution Center at 800-638-0461.

SECTION 1: TELL US WHO YOU ARE (Please print and complete all information)

Full Name:	**Date of Birth:**
Address:	**Phone Number:**
City, State, Zip	**TriNet Employee ID# or Last Four Digits of SSN ONLY:**
Email Address:	

SECTION 2: WHAT IS THE PURPOSE OF THIS AUTHORIZATION? (Please check all that apply)

- ☐ To authorize the identified persons and/or organizations to discuss orally with TriNet the PHI indicated for purposes of Plan claims or eligibility assistance.
- ☐ To authorize the identified persons and/or organizations to inspect and/or obtain copies of the PHI for purpose of Plan claims or eligibility assistance.