# Authorization for Agency/Agent Portal Access (PHI Form)

I, _____, am authorized on behalf of _____ [appointed agency name] to identify the individuals listed below as authorized to receive a username and password to access the Beni Solutions portal and access to information regarding eligibility and enrollment. I understand that eligibility and enrollment information and reports as well as access to the enrollment web portal contain information subject to federal and state privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA), and contain information such as the names, home addresses, dates of birth, and social security numbers of individuals and dependents enrolled in the benefits plan (Enrollment Data). I understand that a person can have different roles when they access Enrollment Data and the portal.

**These roles include the following:**

• Agency – allows a person access to ALL GROUPS where the Agency services an account and includes groups written by ANY agent of this Agency.

• Agent – allows a person access to ONLY the groups where the Agent services an account under your Agency. They cannot view groups that they have not been assigned to.

**Additional Access:**

- Commission Access – allows the user to access commission statements paid to the Agency which includes payment data for ALL Groups associated with the Agency.

Each of the individual(s) whose names appear below are authorized for the following access and roles: Logins will be sent to the email address listed below.

| Name | Email | AgencyAgent Access | Commission Access |
|---|---|---|---|
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Beni Solutions shall be entitled to rely on any additions, deletions, or modifications to the Enrollment Data entered by an authorized individual listed above.

I understand that each of the individuals listed above will have access to Enrollment Data that is the subject of federal and state privacy, security, and data breach laws and that each understands that their access, use, and disclosure of this information shall be limited to an authorized business purpose related to administration of the benefits plan provided by Beni Solutions.

I understand that I have an ongoing responsibility to provide Beni Solutions with prompt written notice if any individual listed above no longer has permission to view or modify Enrollment Data or to have a username and password to the Enrollment Web Portal. I agree to provide written notice to the email address listed below to allow Beni Solutions to disable the user account of any person no longer authorized to access the Enrollment Data or the Beni Solutions enrollment portal.

## Authorized Agency Representative Acknowledgement

| Authorized Signer Name | Signature | Title | Date |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

Email to: **portalsupport@beni.solutions**