BlueAdvantage® *Group*

BlueCross BlueShield of Delaware

MyAdvantageHSA™
Authorization for Release of Information
for a Health Savings Account with *The Bancorp Bank* and for Automatic Credits and Debits to My HSA

Employee's Name		Date of Birth (mm/dd/yyyy)
Social Security Number	Driver's License Number and State Issued	
Address		Apt./Box #
City	State	Zip Code
Work Phone	Home Phone	Email
Employer's Name		

Authorization for Release of Protected Health Information to Establish and Maintain a Health Savings Account with *The Bancorp Bank*

I authorize my employer and/or group health plan to provide Blue Cross Blue Shield of Delaware (BCBSD), and I also authorize BCBSD to provide to *The Bancorp Bank* (*Bancorp*) any and all identifying information necessary for *Bancorp* to open a Health Savings Account (HSA) in my name, including but not limited to my Social Security Number, address, phone number and date of birth. This information may be provided in any format or medium including but not limited to electronic and paper files.

This Authorization is being provided in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations issued thereunder.

This Authorization shall remain in effect for as long as I am covered under a BCBSD qualifying high-deductible health insurance plan that is compatible with an HSA.

I have the right to revoke this Authorization at any time by providing written notice to BCBSD. Revocation of this Authorization shall have no effect on any action that BCBSD or others have taken prior to receipt of my written notice of revocation.

I understand that if I fail to sign this Authorization, BCBSD will not be able to provide information to *Bancorp*, the HSA Custodian, to open and maintain my HSA. I also understand that any and all information provided by BCBSD to *Bancorp* in accordance with this Authorization may be subject to re-disclosure by *Bancorp*, and may no longer be protected by HIPAA.

Authorization for Automatic Credits and Debits to My HSA

I authorize BCBSD and/or *Bancorp* to make credit and debit entries to my HSA where *Bancorp* is the custodian thereof, for the sole purpose of correcting any contributions or any other transactions that may be made in error to or with my HSA.

Employee's Signature	Date (mm/dd/yyyy)

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