



ACCESS REQUEST FORM – ONLINE BENEFIT MANAGER PORTAL – ASC

GROUP INFORMATION

GROUP NAME: _____

GROUP NUMBER: _____

GROUP BENEFIT COVERAGE: Vision Only Dental Only Vision & Dental

GROUP STATE: _____

SUBLOCATIONS: ALL

OTHER: _____

KEY USER INFORMATION

AUTHORIZED KEY USER'S NAME: _____

AUTHORIZED KEY USER'S BUSINESS EMAIL ADDRESS: _____

(Username and password will be emailed to this address)

AUTHORIZED KEY USER'S WORK PHONE NUMBER: _____

Please note only the Authorized Key User, listed above, will have the ability to grant other individuals access to Advantica's online group portal. The Authorized Key User and other individuals granted access by the Authorized Key User will collectively be referred to as "Authorized Individuals." It will be the responsibility of the Authorized Key User to maintain the listing of all users for this organization including any additions, terminations or modifications.

TERMS AND CONDITIONS: Advantica permits groups to open website accounts for use by Authorized Individuals, subject to approval by Advantica in its sole discretion, for the purpose of submitting timely, accurate and complete group enrollment data to Advantica on the Group's behalf. The Group, acting through its undersigned representative, (a) certifies that, subject to Advantica's approval, the Authorized Individuals are authorized to submit enrollment data to Advantica on the Group's behalf; (b) accepts Advantica's Terms and Conditions of Use, available for review online at www.advanticabenefits.com; and (c) agrees to the following conditions: (1) Advantica may rely on this electronically submitted enrollment data to the same extent as if submitted by non-electronic means; (2) Group will undertake reasonable measures to safeguard account information, including username and password, and to prevent unauthorized access to the website account by someone acting or purporting to act on the Group's behalf; (3) the Authorized Key User will not grant access to a third party (i.e., anyone not part of the Group's workforce) as an Authorized Individual unless the third party is a broker, consultant, TPA or other party contracted to perform treatment, payment or health care operations, and the Group has a HIPAA-compliant business associate agreement in place with such third party; (4) Group shall be solely responsible for any liability arising from the use of the website account and shall indemnify, hold harmless and defend Advantica against any claim arising from an Authorized Individual's use of the website account or the Group's failure to safeguard account information, including, but not limited to, errors and omissions and violations of state and federal privacy laws; (5) the individual submitting this application has the authority to permit the requested access and bind the Group to (i) Advantica's Terms and Conditions of Use and (ii) the terms and conditions set forth above.

Group Administrator Name: _____ Group Administrator Phone: _____

Group Administrator's Signature: _____ Date signed: _____

Once completed, please fax to 727-683-8810 or scan and email to GroupPortalHelp@advanticabenefits.com.