BBP Admin
BENEFITS ADMINISTRATION
COBRA, FMLA, FSA, HRA, HSA, TRANSIT
info@bbpadmin.com
www.bbpadmin.com
630 773 2337

## Insurance Carrier Online Enrollment Form – E-Claims Management

Please complete this form in order to have BBPadmin and/or its third party service provider, TPAStream, login to your insurance carrier website as you to retrieve any substantiation in order to satisfy the Federal & IRS law of verifying debit card claims.

I request and authorize BBP and its third party service provider, TPAStream, to retrieve my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

**This form must be completed and given to BBP – Anything in Bold is mandatory**
**You may also register online @** https://www.easyenrollment.net/enroll/easysystem

**Employer Name:** _____

**Employee Name:** _____ Telephone: _____

Employee Address: _____

City: _____ State: _____ Zip: _____

**Social Security Number**: _____ Date of Birth: _____

**E-Mail Address:** _____

Spouse or Children's Names on Insurance _____

☐ Please check this box and send a copy of your insurance card if BBP needs to create an online account with your insurance carrier on your behalf.

**Check here if you already have an account created with your insurance carrier(s) and want to enroll in the EasyClaims System:** ☐

_____
**Insurance Carrier Name**

_____ _____
**User ID** **Password**

_____ _____
**Security Question 1** **Security Answer 1**

_____ _____
**Security Question 2** **Security Answer 2**

_____ _____
**Security Question 3** **Security Answer 3**

***I understand that if the login and/or password changes, I need to update my insurance credentials in my Participant Portal or send BBP Admin the updated login and password.***

Right to Revoke: I understand I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any action the above entities took in reliance on this authorization before the above named entities received my written notice of revocation.

**HIPAA WAIVER**

**I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.**

Employee Signature: _____ Date: _____

**BBPadmin**
**125 West Orchard Street – Itasca, Illinois 60143-1764**
**Phone: 630-773-2337 Fax: 630-773-8568 E-mail: support@bbpadmin.com**

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