Sentinel Benefits & FINANCIAL GROUP
Custom Solutions for Life and Wealth

Account Information Access Request

Upon receipt of this completed form, Sentinel Benefits will share account information with a designated agent of the benefit plan participant. This permission will allow an authorized individual to obtain benefit account information from a Sentinel Benefits Account Representative. Authorization may be granted for information only and not for transactions or account changes, including resetting online account login access. Please note that this information may include Protected Health Information as defined by the Health Insurance Portability and Accountability Act of 1996.

Revocation of this request must be made in writing, and can be sent to Sentinel Benefits at any time.

Instructions:

1. Complete the information below. Please type or print.
2. Fax to 781-213-6770 or email to clientcare@sentinelgroup.com

Participant Information:

LAST NAME _____ FIRST NAME _____ SOCIAL SECURITY NUMBER _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

☐ Home
☐ Office

EMAIL ADDRESS _____ PHONE NUMBER _____

EMPLOYER/PLAN SPONSOR NAME _____

Type of Account:

☐ Pension and Retirement Plans
☐ Flexible Spending Account (FSA)
☐ Health Savings Account (HSA)
☐ Health Reimbursement Arrangement (HRA)
☐ COBRA and Insurance
☐ Other (Please specify): _____

Authorized Individual(s):

LAST NAME _____ FIRST NAME _____

LAST NAME _____ FIRST NAME _____

LAST NAME _____ FIRST NAME _____

Expiration Date:

This authorization will expire as follows (choose one):

○ When my coverage expires
○ On this specified date: _____

Participant Signature:

PLAN PARTICIPANT _____ DATE _____