AUTHORIZATION FOR EMPLOYEE(S)
TO ACCESS PROTECTED HEALTH INFORMATION ("PHI")

The Plan Sponsor of the ____hereby authorizes the following employees of Plan Sponsor to access Protected Health Information ("PHI") with respect to the self-funded employee welfare and prescription benefit plan(s) for which Meritain Health, Inc. and Scrip World, LLC provide the administration services (the "Protect Plans") as set forth respectively under the Agreements ("the Plan").

Employees(s) of Plan Sponsor

(Please provide names, titles, and identifiers of the employee(s)/associate(s) that may have access)

Name	Title / Email Address
______________________	______________________
______________________	______________________
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Please add additional lines if necessary.

Plan Sponsor has trained (and will continue to train) the above referenced employees on the proper uses and disclosures of Protected Health Information.

This authorization is effective until later revised or revoked in writing by the Plan Sponsor.

Signature of Plan Sponsor: ________________________________

Printed Name and Title: ________________________________

Date: ______________