Sign-on – Self Funded Employer Form

The purpose of this form is to establish an Employer Account which will provide you with secure sign-on access to a generalized overview of your employees' precertifications de-identifying any and all protected health information. (Note: online access is for Self-Funded Employers only - not employers under Fully Insured plans). Please be aware that you, as the designated representative of your employer group, are also responsible for granting (and terminating) your broker/agent's access to your account. Once you have agreed in writing to allow broker/agent access, your groups' generalized overview data can be accessed by your agent/broker after they have completed a registration form. A Business Associate agreement between you and Sentinel is also required to be signed and forwarded which is available online.

Please complete the following information:

Employer Name: _____

Group #: _____

Designated Representative Information:

You are responsible for following the Logon Terms of Use as posted by Sentinel and available online. Once your registration has been completed, an access ID will be assigned to you.

Please provide the following information to register:

Name (First, MI, Last): _____

Title: _____

Work Address: _____

City / State / Zip: _____

Work Phone Number: _____

Email Address: _____

Please check 1 of the following:

- ☐ **Allow** agent/broker online access
- ☐ **Do not allow** agent/broker online access

Name of Agent/Broker: _____

******Login information will be sent to the email listed above******

Request and Agreement:

I hereby request establishment of a Self funded Employer secure Sign-on under www.sentinel4health.com. Please establish the account pursuant to the information above. I understand Sentinel must be notified promptly of any changes to this information (i.e. I no longer am employed by the Employer, I no longer wish agent access to my account, etc.). By signing below, I acknowledge I have read the Logon Terms of Use and agree to the terms and conditions therein and will be asked to accept or decline each time I log in. I understand a Business Associate Agreement must be completed before access is granted. For purposes of this Agreement, my signature on this form when communicated by facsimile transmission or as a scanned document sent via email shall be binding if transmitted in either fashion with electronically reproduced signatures treated as original.

This form must be signed by a designated representative of the Self Funded Employer requesting access and will be verified with the contact listed in Sentinel's records:

Signed: _____

Print Name: _____

Title: _____

Date: _____

Fax to	**717-581-8841**
Mail to	**Sentinel Management - PO Box 8377, Lancaster, PA 17604**
Email to	**info@sentinel4health.com**