

Security Administration Form—Plan Sponsor Use Only

This form addresses access to Wespath Benefits and Investments (Wespath) administration websites.

Part 1 – User Information. Submit one form for each authorized user.

User name (first/last name) _____	New user? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Remove
Title/job position _____	Organization # _____
Home address _____	User e-mail address _____
_____	Conference # _____
Plan sponsor representative _____	Phone # _____

Part 2 – Access to Applications. Please check all boxes that apply. By checking a box, you are representing to Wespath that the user identified in Part 1 is authorized to have access to all or part of the application.

<input type="checkbox"/> Benefits Access for Plan Sponsors (check one):	<input type="checkbox"/> Comprehensive Benefit Funding Plan (CBFP) Portal
<input type="checkbox"/> Inquiry—allow online payments; no payroll file upload	<input type="checkbox"/> Benefitsolver* (check one):
<input type="checkbox"/> Administrative—allow online payments and file upload	<input type="checkbox"/> View
<input type="checkbox"/> Also allow access to Benefits Access for Participants	<input type="checkbox"/> Update
<input type="checkbox"/> Also allow access to Benefits Access for Participants with health	<input type="checkbox"/> HealthFlex Billing ⁺
<input type="checkbox"/> Contribution Management	<input type="checkbox"/> Virgin Pulse Administrative
<input type="checkbox"/> Institutional Investor Portal (check one):	<input type="checkbox"/> Quest Diagnostics Administrative**
<input type="checkbox"/> Inquiry	<input type="checkbox"/> WageWorks Administrative**
<input type="checkbox"/> Transactional***	<input type="checkbox"/> Reports
<input type="checkbox"/> Transactional Authorize***	<input type="checkbox"/> Unum Campus Administrative

* HealthFlex and Virgin Pulse plan sponsors
 ** HealthFlex plan sponsors only
 *** Home address is needed for this access level
 + HealthFlex Billing Access Requests may take up to 10 business days to complete so please submit as soon as is necessary

Part 3 – Church/Employer Information. Complete this section only if you have requested access to lay participant data.

List the salary-paying units for which you are the plan sponsor and for which the user listed in Part 1 is to have access.

Salary-Paying Unit Name (For access to related participant data)	Number
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Note for HealthFlex plan sponsors: If Wespath has a current *Salary-Paying Unit Sub-Adoption Agreement* on file for lay employees, the appropriate security access is granted automatically.

(over)

Part 4 – Confidentiality Agreement

In order to perform my duties as a benefits administrator for the salary-paying units listed in Part 3 of this form, for which my employer is the plan sponsor, I may need to access account, indicative and other information of a sensitive, proprietary, privileged and/or confidential nature (Confidential Data) relating to certain participants of the retirement, health and welfare plans that the General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois (Wespath) administers.

In consideration for being able to access such Confidential Data, I agree that I will not distribute, disclose or convey any Confidential Data to anyone or reproduce any Confidential Data, unless I am required or legally compelled to do so within the course of my employment duties, provided that I will notify Wespath immediately if I receive notice of such legal requirement. I also agree that I will not make use of any Confidential Data for my own benefit or for the inappropriate benefit of any other person or entity. Confidential Data will be used only for benefits purposes and not to make employment or personnel decisions. I acknowledge that Confidential Data can include Protected Health Information (PHI) as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I agree to use and disclose any such PHI only as permitted under HIPAA.

I agree that all Confidential Data shall at all times remain the property of Wespath and the relevant benefit plan(s), that Wespath has a legitimate interest in protecting the confidentiality of the Confidential Data and that disclosure of any Confidential Data to an unauthorized third party could cause irreparable harm to Wespath. I understand that Wespath may take legal action to protect these interests.

I agree that the terms of this Confidentiality Agreement will continue to be in effect even after the termination of my employment with the plan sponsor.

User name (please print) _____

User signature _____ Date _____

Approval of plan sponsor representative (please print) _____

Signature _____ Date _____

Please mail or fax the completed form to the Client Service Management Team at **1-847-866-4894**.

Part 5 – Wespath Use Only

☐ Client service manager ☐ Client relationship manager

Wespath authorized personnel _____ Date _____

For Benefits Access only: ☐ Conference ☐ Agency ☐ Plan sponsor

Wespath service desk _____ Date _____

Final Distributions

- **Service desk:** File original (final) copies for follow up reviews/audits.