WA HEALTH BENEFIT EXCHANGE – USER ACCESS AGREEMENT

I, _____(Full legal name), understand and agree that:

1. I will be given access to information submitted to and records stored by the Washington Health Benefit Exchange ("the Exchange"). That information includes confidential personal and financial information gathered from applicants, qualified individuals, or enrollees through the Healthplanfinder webpage that can be used only for Exchange business purpose.
2. I will only create, collect, use, or disclose confidential personal and financial information to the extent it is necessary to carry out my authorized role with the Exchange, and for no other purpose.
3. I will disclose confidential personal and financial information only to individuals who are authorized to receive or view it. If I receive any request for information from an unauthorized person or uncertain entity, I will promptly refer the request to the Healthplanfinder **Navigator Team** at navigator.lms@wahbexchange.org and to my supervisor and/or Lead Organization.
4. I will not disclose my password or any other account information to anyone, and will not allow anyone else to use or have access to my Healthplanfinder account.
5. I will not use my account in a manner that is illegal, that could lead to disruption of the Healthplanfinder services, or that could pose a risk to the security of the Healthplanfinder.
6. I will immediately report any unauthorized access or disclosure of confidential personal and financial data. I will report any breach to the Healthplanfinder **Navigator Team** at navigator.lms@wahbexchange.org and to my supervisor and/or Lead Organization.
7. I have received a copy of and read the Exchange's privacy policy, and have received training on the Exchange's privacy and security standards.
8. I will comply with all policies and procedures of the Exchange regarding privacy and security of confidential and personal information in accordance with 45 CFR 155.260. I understand that any violations of the nondisclosure of confidential and personal information requirements may subject me to civil fines up to $25,000 per use or disclosure.
9. The terms and conditions of this agreement will remain in effect after I leave my current position. I will not disclose confidential personal and financial information that I obtained while working in my position.
10. I understand that any breach of any provision of this Agreement will subject me to immediate termination of my access to the Healthplanfinder.

My signature below acknowledges that I have read, understand, and agree to abide by the constraints associated with the use and disclosure of information submitted to and stored by the Exchange.

_____ _____

Signature of User Date

_____

Certification Number

Please Return Original to:
Attn: Navigator Program
Washington Health Benefit Exchange
PO BOX 657
Olympia, WA 98507

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