

## ONLINE NETWORK FOR HEALTH PLANS SECURITY AGREEMENT

Wis. Stat. § 40.07 (1)

REQUEST TYPE (please check one)

- |  |  |
|--|--|
| <input type="checkbox"/> Add new employee                    | <input type="checkbox"/> Add application access for existing employee    |
| <input type="checkbox"/> Delete existing employer            | <input type="checkbox"/> Delete application access for existing employee |
| <input type="checkbox"/> Change access for existing employee | <input type="checkbox"/> Name change for existing employee               |

I. **Employee:** Read the provision set forth below and complete your name, work address, work phone number, e-mail, signature and date below.

I understand that security measures have been established to provide necessary inquiry abilities for the state of Wisconsin Public Employee Health Insurance System. I agree to maintain the confidentiality of all information that I obtain through on-line access to health insurance accounts. I understand that information in these accounts is not a public record and disclosure to any person or organization is absolutely prohibited.

I further understand that the Online Network for Health Plans is intended for use by health plans to administer Department of Employee Trust Funds (ETF) benefit programs and is not intended to provide information to members or to assist members in making benefit decisions.

I have read the provision set forth above. I understand that Wisconsin statutes, § 943.70 provide criminal penalties for offenses against computer data and programs. Violation of this provision will result in termination of my online access to member accounts and/or termination of my health plan's online access to member accounts.	
Employee Name/Work Address/Work Phone Number:	ETF Security Administrator Use Only
Employee Signature/Date:	Logon ID
Employee E-mail Address:	ETF Security Administrator Signature/Date

II. **Health Plan Authorizing Individual:** Certify that the above employee is authorized to gain access to the Online Network for Health Plans by completing the area below and checking those applications for which authorization is being requested. Please notify ETF immediately if your authorized employee terminates or loses authorization.

### MYETF BENEFITS FOR HEALTH PLANS

- Health eligibility inquiry  
 Health premium inquiry

I understand that Wisconsin statutes, § 943.395, provide criminal penalties for knowingly making false or fraudulent claims on this form and hereby certify that, to the best of my knowledge and belief, the above information is true and correct. I certify that I am responsible for reporting information to ETF.	
Authorizing Individual Name/Work Address/Work Phone Number:	ETF Security Administrator Use Only
Authorizing Individual Signature/Date:	Logon ID
Authorizing Individual E-mail Address:	ETF Security Administrator Signature/Date

III. **ETF Security Officer:** Will issue each designated employee a Logon ID, password and PIN to gain access to the system. Please allow two to three weeks to receive authorization and instructions for access.