SHBP FILE UPLOAD ACCESS AGREEMENT

For access to the State Health Benefit Plan File Upload Application, I agree to keep confidential my personal access login, password and any information I may learn by accessing this system. I understand that the information being transmitted through the File Upload Application contains personal information on employees within my payroll location and that HIPAA regulations require that this information be held in confidence. I also agree to notify the State Health Benefit Plan IT Help Desk at 404-463-0212 should my position change and I no longer need access to the File Upload Application.

_____	_____
Signature	Date
_____	_____
Print Name	Payroll location number/s
_____	_____
Telephone Number	Witness Signature
_____	_____
e-mail address	Print Witness Name

Completed form should be faxed to 866-545-3161.

SHBP USE ONLY

Date User Name Assigned _____

User Name _____

Initial Password _____

User Notified: _____

Termination Date _____ Directed to terminate by_____