

VIEW DIRECT ACCESS AGREEMENT

For access to the State Health Benefit Plan View Direct System, 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 in this View Direct System 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 View Direct System.

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 ID Assigned _____

User ID _____

Initial User Password _____

User Notified: _____

Termination Date _____ Directed to terminate by _____