UAB Retirees Association

UABRA Newsletter

January 2022

Greetings From Your President

What a joy it was to finally see old friends and new on October 19, 2021, at the Homewood Library. Dr. Robert Glaze entertained us with stories about UAB's history and his personal memories, several of which had us laughing. To be safe, everyone wore masks except when addressing the group or being photographed. We also had a good group of attendees on Zoom who reported they were easily able to see, hear, and enjoy the program with us. Hospitality Chair Mindy Lalor provided a bountiful supply of Halloween treats to take home.

As much as we enjoyed being together again, reality prevails. UAB Hospital on January 3 had 105 COVID-19 patients in the hospital, 28 of them in ICU, and 11 on vents. Only 3 weeks earlier, on December 14 there were just 16 COVID-19 patients in the hospital. So, we pivot back to Zoom for now.

See you on January 18 at 1 pm on Zoom for "Save Our RSA Retirement." Happy New Year!

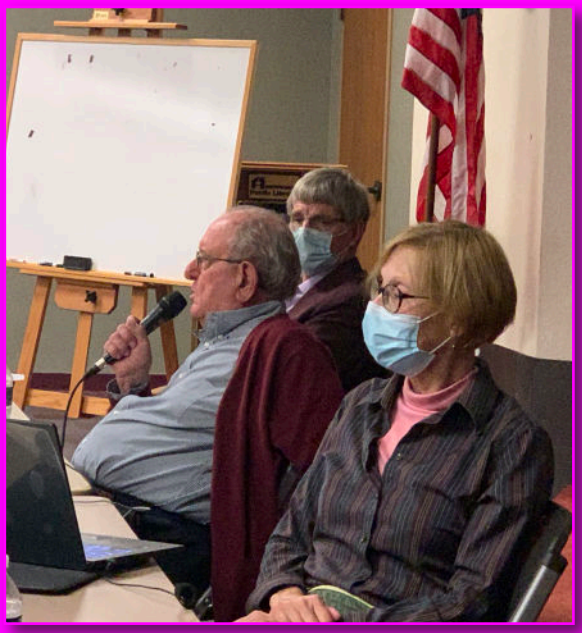
– Laura Atkinson

STAY INFORMED

Did you know that unless you complete a release form and submit it to PEEHIP, your loved ones cannot inquire about your insurance coverage nor advocate for you with PEEHIP if you become incapacitated. Your spouse needs a release on file for the same reason.

For your convenience, see pages 3 and 4 for the PEEHIP release form and the equivalent Humana form.

Plan ahead!



Top: Dr. Glaze was the center of attention

Below: Dr. Michael Anne Markiewicz, managing Zoom, and Dr. Clint Bruess, Moderator, on either side of Dr. Glaze

Laura Atkinson's tour guides, Haley Galloway and Emily Whitmire, at the Community Food Bank of Central Alabama

UABRA 2021 DONATIONS

March - Christopher Kids, $500
December – Blazer Kitchen, $500;
Community Food Bank of West Alabama, $1,000

TAKE ACTION

It's not too late to download and send in your 2022 UABRA membership form.

Laura Atkinson attended a regional AERA meeting in Cullman on December 16. Speaker of the Alabama House of Representatives Mac McCutcheon believes retirees will receive a bonus but could not commit to an amount. AERA believes there is support for a bonus as large as the $2,000 they are working for. **Call/write/email your legislators!**

Enter your volunteer hours at UABretirees.org. There is power in numbers. We can let our legislators know how much retirees contribute to the well-being of our communities.

Volunteer to serve on UABRA's Board of Directors. Terms are three years. Nominations are open now for the 2022-2025 Board. Current Board Members are retirees from across UAB.

UPCOMING EVENTS in 2021-2022

Tuesday, January 18, 2022, 1:00pm.

NOTE: This meeting is on Zoom only. Look for the link in the email.

"Save Our RSA Retirement" provides critical updates on the latest efforts to undermine the security of RSA retirement. Learn what we can do to help protect RSA's present and future stability, just in time to plan action for the Spring legislative session.

David Harer, Huntsville Fireman, President of Professional Firefighters of Alabama, and Active Local Government Representative on the ERS Board of Control, Position #1; Geoff Statum, Retired Huntsville Firefighter and Lead Administrator of the Save Our RSA Retirement group Facebook page; and Lisa Statum, Active Local Government Representative on the ERS Board of Control, Position #2.

UABRA Annual Meeting
Speaker to be announced. Homewood Public Library, Tuesday, May 10, 2022, 1:00pm.

Stay tuned as new programs are listed.

TO LEARN MORE ABOUT UABRA

NEW email address coming soon!

UABRA@UABretirees.org. will replace UABretireesasso@gmail.com

Check out our website at UABretirees.org for much more information or to download the membership form.

Join the Facebook "Save Our RSA Retirement" Group for ongoing information and updates.

Contact UABRA by mail at: PO Box 55682, Birmingham, AL 35255

PEEHIP HIPAA Privacy Authorization
Retirement Systems of Alabama
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

Participant SSN ___ ___ ___ ___ ___ ___ ___ ___ ___

Authorization for Use or Disclosure of Protected Health Information *(Required by the HIPAA - 45 CFR Parts 160 and 164)*

Authorization Information

I, _____ , hereby authorize PEEHIP to disclose the protected health information ("PHI")
Participant Name (printed)

described below to:

Name _____ Relationship _____

❑ by telephone

❑ by email at _____

❑ by mail at _____
Street or P.O. Box City State ZIP Code

Authorization for release of PHI covering the time period **(check one):**

❑ from *(date)* _____ to *(date)* _____
❑ all past, present, and future periods.

I hereby authorize the release of PHI as follows **(check one):**

❑ my complete PEEHIP file including records relating to mental health care, communicable disease, HIV or AIDS, and treatment of alcohol/drug abuse
❑ my complete PEEHIP file with the exception of the following information **(check as appropriate):**
- ❑ mental health records
- ❑ communicable diseases (including HIV and AIDS)
- ❑ alcohol/drug abuse treatment
- ❑ other *(please specify)* _____

Authorization Certification

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until nine (9) months after my death or _____ *(date or event)* at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time by submitting the revocation to PEEHIP. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Sign Here → **Participant Signature** _____ **Date** _____

Address _____
Street or P.O. Box City State ZIP Code

Date of Birth _____

Consent for release of protected health information (PHI)

Member information (person whose information will be released):

Name: _____ Date of birth: _____ / _____ / _____
First Middle Last Month Day Year

Address: _____
Street City State ZIP

Member ID: _____ Group # (if applicable): _____ Phone #: _____
❑ Home ❑ Cell*

I understand that this authorization will allow Humana and its affiliates to use or disclose the protected health information described below:** (Please check only **one** box)

❑ Full Disclosure: Any protected health information Humana and its affiliates maintains, including mental health, HIV, health status or substance use or disorder records. This also includes sharing information on mail-order pharmacy, wellness products, and health programs with the person being authorized.

❑ Limited Disclosure: You specify what PHI to share. Ex. condition or treatment information, a specific date range, or product type. Unless you limit by product type, information will apply to all products and services. _____

_____

If Limited Disclosure was selected please indicate which product(s) apply:

❑ Medical and/or Prescription coverage ❑ Vision ❑ Dental ❑ Humana Pharmacy (mail delivery) ❑ Go365

This information may be disclosed to, and used by, the following person or organization (such as nursing home, care provider, and care managers) to assist me with the Humana-owned products or services for which I am providing consent to disclose information:

Name: _____ Date of birth: _____ / _____ / _____
First Middle Last *Required Field* Month Day Year

Or if organization: _____
Name

Address: _____
Street City State ZIP

Email: _____ Phone #: _____
❑ Home ❑ Cell*

Relationship: ❑ Spouse ❑ Sibling ❑ Parent ❑ Child ❑ Agent/Broker ❑ Friend ❑ Organization

I understand:

·I am not required to fill out this consent and Humana cannot base decisions regarding treatment, payment, enrollment or eligibility for benefits on whether I submit it.

·Disclosures may include information from past, present, and/or future treating providers.

·This consent is valid until I cancel my Humana membership. For customers in the following states, CA, CT, GA, IL, MA, MD, MT, NC, NJ, NV, OH, OR, PR, VA consents will expire in compliance with applicable state laws.*** I can cancel my consent at any time through my MyHumana account, by calling customer service, or by submitting a written notice to Humana.

·If I cancel consent, it will not apply to any information previously released with this authorization. Once information is shared, Humana cannot prevent the person or organization who has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations.

Member or Legal Representative signature _____ Date: ____ / _____ / _____

❑ Member ❑ Legal Representative

Please note: Legal representatives must attach copies of authorization as required by law. Examples include healthcare power of attorney, healthcare surrogate, living will or guardianship papers.

After you complete and sign the form, please fax it to **1-800-633-8188. OR** If you prefer, mail your completed form to: **Humana Insurance Company, P.O. Box 14168, Lexington, KY 40512-4168**

Humana.

* By giving your cell phone number, you give Humana permission to make calls to your cell
** Health includes Medical, Dental, Pharmacy, Behavioral Health, Vision, Long-Term Care
*** Expires in 12 months: CA, CT, GA, IL, MA, MD, NC, NJ, NV, OH, OR
Expires in 24 months: MT, VA & Puerto Rico

 Humana will follow the more stringent of all federal and state laws and regulations.

For Humana Use Only