Wespath
BENEFITS | INVESTMENTS

1901 Chestnut Avenue
Glenview, Illinois 60025-1604
wespath.org

Security Administration Form—Plan Sponsor Use Only

This form addresses access to Wespath administration websites.

Part 1 – User Information. Submit one form for each authorized user.

User name (first/last name) _____ New user? ☐ Yes ☐ No ☐ Remove

Title/job position _____ Organization # _____

Home address _____ User e-mail address _____

_____ Conference # _____

Plan sponsor representative _____ Phone # _____

Part 2 – Access to Applications. Please check all boxes that apply. By checking a box, you are representing to Wespath that the user identified in Part 1 is authorized to have access to all or part of the application.

- ☐ Benefits Access for Plan Sponsors (check one):
  - ☐ Inquiry—allow online payments; no payroll file upload
  - ☐ Administrative—allow online payments and file upload
    - ☐ Also allow access to Benefits Access for Participants
    - ☐ Also allow access to Benefits Access for Participants with health
- ☐ Contribution Management
- ☐ Institutional Investor Portal (check one):
  - ☐ Inquiry
  - ☐ Transactional**
  - ☐ Transactional Authorize**
- ☐ Comprehensive Benefit Funding Plan (CBFP) Portal
- ☐ Empyrean* (check one):
  - ☐ View
  - ☐ Update
- ☐ HealthFlex Billing+
- ☐ Unum Campus Administrative

* ***HealthFlex and Personify Health plan sponsors***
** ***Home address is needed for this access level***
+ ***HealthFlex Billing Access Requests may take up to 10 business days to complete so please submit as soon as is necessary***

Part 3 – Church/Employer Information. Complete this section only if you have requested access to lay participant data. List the salary-paying units for which you are the plan sponsor and for which the user listed in Part 1 is to have access.

Salary-Paying Unit Name (For access to related participant data)	Number

Note for HealthFlex plan sponsors: If Wespath has a current *Salary-Paying Unit Sub-Adoption Agreement* on file for lay employees, the appropriate security access is granted automatically.

Part 4 – Confidentiality Agreement

In order to perform my duties as a benefits administrator for the salary-paying units listed in Part 3 of this form, for which my employer is the plan sponsor, I may need to access account, indicative and other information of a sensitive, proprietary, privileged and/or confidential nature (Confidential Data) relating to certain participants of the retirement, health and welfare plans that Wespath administers.

In consideration for being able to access such Confidential Data, I agree that I will not distribute, disclose or convey any Confidential Data to anyone or reproduce any Confidential Data, unless I am required or legally compelled to do so within the course of my employment duties, provided that I will notify Wespath immediately if I receive notice of such legal requirement. I also agree that I will not make use of any Confidential Data for my own benefit or for the inappropriate benefit of any other person or entity. Confidential Data will be used only for benefits purposes and not to make employment or personnel decisions. I acknowledge that Confidential Data can include Protected Health Information(PHI) as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I agree to use and disclose any such PHI only as permitted under HIPAA.

I agree that all Confidential Data shall at all times remain the property of Wespath and the relevant benefit plan(s), that Wespath has a legitimate interest in protecting the confidentiality of the Confidential Data and that disclosure of any Confidential Data to an unauthorized third party could cause irreparable harm to Wespath. I understand that Wespath may take legal action to protect these interests.

I agree that the terms of this Confidentiality Agreement will continue to be in effect even after the termination of my employment with the plan sponsor.

User name (please print)_____

User signature_____ Date _____

Approval of plan sponsor representative (please print)_____

Signature _____ Date _____

Please mail or fax the completed form to the Client Service Management Team at **1-847-866-4894**.

Part 5 – Wespath Use Only

❑ Client service manager ❑ Client relationship manager

Wespath authorized personnel _____ Date _____

For Benefits Access only: ❑ Conference ❑ Agency ❑ Plan sponsor

Wespath service desk _____ Date _____

Final Distributions

• **Service desk:** File original (final) copies for follow up reviews/audits.