ADMINISTRATIVE USE ONLY:
Received
By: _____
Date: _____

NOTICE OF AUTHORIZED REPRESENTATIVE AND/OR PERSONAL REPRESENTATIVE

A. COVERED PERSON/MEMBER:

Name: _____ Social Security #: _____
(Last) (First) (Middle Initial)

Home Address: _____ Work Phone #: _____

_____ Home Phone #: _____

_____ Date of Birth: _____

Name of Participating Group or Plan: _____

If you are not a member of the above group or Plan, please indicate:

- Your relationship to the member: ☐ Spouse ☐ Child ☐ Other (describe):_____
- The member's Social Security #_____

B. AUTHORIZED REPRESENTATIVE:

Name: _____ Phone #: _____
(Last) (First) (Middle Initial)

Address: _____ Fax #: _____

Relationship to Covered Person/Member:_____ Date of Birth: _____

C. AUTHORIZATION:

I, _____, hereby authorize the Authorized Representative identified above to act on my behalf on the following matters: (*choose one or both*)

☐ Claim Filing and Appeals. All matters relating to the claim filing and appeal procedure under the *[name of plan]* (the "Plan"), including sending and receiving any and all past, present or future eligibility, coverage, health or other information about myself in connection with the Plan's claim filing and appeal procedure.

☐ Privacy of Protected Health Information. All matters relating to my rights under the federal regulation (pursuant to Health Insurance Portability and Accountability Act of 1996, as may be amended) governing the privacy of my protected health information created or received by the Plan, including matters relating to the exercise of any right I may have to (i) provide authorization or consent for use or disclosure of such health information or (ii) request access, amendment, accounting, restrictions, confidential communications, or notice of privacy practices. I understand that this authorization may be invalid to the extent prohibited by applicable law that is not subject to preemption by the Employee Retirement Income Security Act of 1974, as amended.

I understand that the Plan Administrator (and/or its designated agent) may deem any act or omission by the Authorized Representative in any matter covered by this authorization as if they are my own act or omission, and that the Plan Administrator (and/or its designated agent) will have no duty to separately confirm the authority of the Authorized Representative. This authorization does not provide anyone the authority to act on my behalf regarding any matter not covered by this authorization. This authorization is valid for 180 days following the date of my signature below or until the Plan Administrator (or a designated agent) receives a written notice from me that specifically terminates this authorization, whichever is earlier. This authorization revokes any and all previous authorizations that I may have signed with respect to the foregoing matter(s).

Signature of Covered Person: _____ Date: _____

D. NOTARIZATION (*Required*)

STATE OF _____)
COUNTY OF _____)

I, _____, a Notary Public, do hereby certify that on this ____ day of _____, 20__, personally appeared before me _____, known to me to be the person whose name appears in section A of this document, and swore and acknowledged to me that he/she executed this document for the purpose expressed above.

_____
Notary Public, State of _____
Name, Typed or Printed: _____
My Commission Expires: _____