ADMINISTRATIVE USE ONLY:

Received By:____________________

Date:__________________________

APPOINTMENT OF AUTHORIZED REPRESENTATIVE
4th DISTRICT IBEW
HEALTH PLAN

A. Covered Individual/Participant

Name: ______________________________ Social Security #:_____________
Home Address:____
____
Work Phone Number:____
Home Phone Number:____
Date of Birth:____

If you are not a Participant of the Plan, please indicate:

- Your relationship to the member
  □ Spouse □ Child □ Other (describe)_____________________
- The Participant's Social Security number____________________________

B. Authorized Representative:

Name: ______________________________ Phone Number:___________________
Home Address:____
____
Date of Birth:____
Relationship to Covered Individual/Member:_________________________________

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 4th District IBEW Health Plan (the "Plan"), including sending and receiving any and all past, present and future eligibility, coverage, health or other information about myself in connection with the Plan's claim filing and appeal procedures.

□ Privacy of Protected Health Information. All matters relating to my rights under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and any other laws governing the privacy of my protected health information created or received by the Plan, including but not limited to matters

related to the exercise of any right I may have to (i) provide authorization or consent for use or disclosure of such health information, (ii) receive notices of any breach of my protected health information; (iii) 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.

You will need to complete an Authorization Form (in addition to this form) for PHI Disclosure before the Plan can share your PHI.

I understand that the Plan Administrator (and/or its designated agent) may deem any act or omission by the Authorized Representative in any manner 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 that is 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 Individual:______________________________Date:__________

D. Notarization (*Required*):

State of______________________)
County of____________________)

I, _______________________________, a Notary Public, do hereby certify that on this _________ day of ________________, 20__, _________________________________ appeared before me, is known to me to be the person whose name appears in Section A above in this document and swore and acknowledged to me that s/he executed this document for the purpose expressed above.

Notary Public, State of ____
Name, Typed or Printed____
My Commission Expires:____