Greater Pennsylvania Carpenters Medical Plan
Appointment of Personal Representative

I, _____ [Name of Participant or Beneficiary]

Mailing address:_____

Phone: (_____)_____

hereby designate: _____ [Name of Authorized Representative]

Mailing address: _____

Phone: (_____)_____

Relationship to Participant or Beneficiary _____ to act on my behalf or on behalf of: _____ [Name of Dependent]

[ ] I authorize my Personal Representative to act for me [and for my covered spouse or dependent, if named above,] in receiving any information that is (or would be) provided to me as a participant/beneficiary of the Plan, including but not limited to, any information that relates to my claim for coverage or benefits under the Plan and any individual rights that I have regarding my protected health information under HIPAA.

[ ] I authorize my Personal Representative to act for me and for my covered spouse and dependents (if named above) in receiving the following protected health information to conduct the following functions on my behalf:

_____

I understand that this designation is subject to approval by the Plan. I also understand that, once approved, this designation will remain in effect unless I revoke it. I understand that I have the right to revoke this designation at any time by submitting a signed statement to that effect to the Plan Office.

I certify that I have reviewed the Plan's Policy for Recognition of Personal Representative.

_____ _____
Participant or Beneficiaries' Signature Date

_____ _____
Authorized Representative's Signature Date

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