Greater Pennsylvania Carpenters Medical Plan
Opt-Out of Personal Representative

Name of Individual: _____

Mailing Address: _____

_____

Phone No.: _____

Name of Participant: _____

Date: _____

I am requesting that: List Individual(s)_____, **NOT** be considered my personal representative and that all correspondence related to my coverage and benefits be mailed to my attention at the address specified above. I understand that my Protected Health Information will not be released to them.

Additional information: _____

_____

_____

_____

This Opt-Out of Personal Representative Form must be filed with the Privacy Official. The Privacy Official must review all requests and may deny any requests based upon state law restrictions.

I 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.

Signature of Individual Requesting Opt-Out: _____

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