Appointment of Authorized Representative

You may appoint one authorized representative, and only one representative, at a time to assist you in appealing an unfavorable claim determination. If you appoint such a representative, he/she shall be authorized to represent you in all matters concerning your claim or appeal. If you have appointed an authorized representative, references to "Patient" or "Covered Plan Participant" in the terms and provisions of the applicable Plan and its Summary Plan Description refer to the authorized representative.

I, _____ do hereby appoint _____
(Name of Claimant) (Name of Representative)
(hereinafter my "Authorized Representative") to act on my behalf in pursuing a benefit claim, specifically

_____

_____

_____
(description of claim and/or treatment including specific date of service)

My Authorized Representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the Claim, any requests for documents relating to the Claim and any appeal of an adverse determination for the Claim.

I understand that in the absence of a contrary direction from me, the Plan will direct all information and notices regarding the Claim to which I otherwise am entitled, including benefit determinations, to my Authorized Representative only.

I am aware that the Standards for Privacy of Individually Identifiable Health Information set forth by the U.S. Department of Health and Human Services govern access to medical information. I understand that in connection with the performance of his/her duties hereunder, my Authorized Representative may receive my Protected Health Information, as defined in the Privacy Standards, relating to the Claim. I hereby consent to any disclosure of my Protected Health Information to my Authorized Representative.

Date: _____ _____
Signature of Claimant

Group: _____ _____
Signature of Employee

ACKNOWLEDGEMENT

I, _____, have read the above Designation of Authorized Representative and I hereby accept this designation and agree to act as Authorized Representative for _____ with respect to the Claim defined above.

Date: _____ _____ _____
Signature of Representative Relationship to Claimant

Notices may be sent to the Authorized Representative at the following address and telephone number.

Name: _____

Address: _____

City, State, ZIP: _____

Telephone Number: _____

Rev. 07/30/2013