

Personal Representative Form

PURPOSE: This form is used to appoint a personal representative for the Individual identified in Section A. CenBen USA, Inc. will provide Protected Health Information (PHI) about the Individual to the appointed Personal Representative and provide that same Representative with the same PHI that is entitled to be provided to the Individual.

SECTION A: Individual Requesting Appointment of Personal Representative

Covered Employee's Name: _____ Employee's SSN: _____ - _____ - _____
Covered Employee's Employer: _____ Current Phone: _____ - _____ - _____
Name of Individual Making Request: _____ Individual's SSN: _____ - _____ - _____
Current Address: _____

SECTION B: Identification of Personal Representative

You have the right to authorize the PHI held by us, your claims administrator, be released to and/or received by the Representative identified in this section. The Representative you identify below may not be subject to federal health information privacy laws. If this is the case, they may further release your PHI and federal information laws may no longer protect it.

This authorization is voluntary. We will not condition your enrollment or eligibility for benefits on receiving this authorization.

You may revoke this authorization at any time by giving written notice to CenBen USA, Inc. Cancellation of this authorization will not affect any action we took prior to receiving your written notification. Please contact CenBen USA, Inc.'s Customer Service Department for more information if you desire to cancel this authorization.

Please state your reason for making this request: _____

Personal Representative's Name: _____

Personal Representative's Relationship to Individual: _____

Personal Representative's SSN: _____ - _____ - _____ Representative's Telephone: _____ - _____ - _____

Personal Representative's Address (Note – all correspondence for the Individual making this request will be sent to the following address):

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Personal Representative Form

SECTION C: Signatures

I, _____, hereby swear that I am the individual listed above or that I have the legal authority to appoint a representative for the Individual listed. Further, I authorize the request and release of my confidential information held by CenBen USA, Inc. to my personal representative. By appointing the person named above as my personal representative, I understand that I am authorizing CenBen USA, Inc. to provide this person with access to my protected health information (PHI), the right to talk to CenBen USA, Inc. about my medical care, and the right to make decisions that will bind me.

Individual's Printed Name

Date

Individual's Signature

Date

If the Individual is unable to give consent because of physical condition or age, complete the following:

Individual is unable to give consent because: _____

I hereby accept the above appointment. I understand that federal and/or state confidentiality laws protect any protected health information (PHI) disclosed to me and I am prohibited from making any further disclosures without the specific authorization of the individual.

Personal Representative's Printed Name

Date

Personal Representative's Signature

Date

To safeguard your privacy and insure no one other than the person you designate receives your PHI, this request must be notarized. (Notary Services can often be provided free of charge at a bank with whom you maintain an account).

Date: _____ Notary Public Signature: _____

Please submit this request to HealthSCOPE Benefits at any of the following addresses:

HIPAA Official
P.O. Box 1224
Little Rock, AR 72203
or

Customer Service – HIPAA
PO Box 16526
Columbus, Ohio 43216
or

Customer Service – HIPAA
PO Box 50440
Indianapolis, IN 46250

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM