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I.B.T. Local 191 Health Services & Insurance Plan

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CONNECTICUT ONLY 1-800-972-4099
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DESIGNATION OF AUTHORIZED REPRESENTATIVE
(For a Specific Claim or Event)

Name of Claimant: _____

Name of Member: _____

Member Social Security Number: _____

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

_____
(Description of Claim including date of treatment or event)

(the "Claim"). 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 of the Claim.

I understand that in the absence of a contrary direction from me, Tri-State Joint Fund (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 (the "Privacy Standards"), 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

ACKNOWLEDGMENT OF AUTHORIZED REPRESENTATIVE

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 Authorized Representative

Notices may be sent to the Authorized Representative at the following address:

_____

_____

_____