SHEET METAL WORKERS LOCAL 46

AUTHORIZATION TO DESIGNATE A PERSONAL REPRESENTATIVE FOR ALL FAMILY MEMBERS

(PLEASE PRINT ALL INFORMATION)

Section A: Family members requesting a personal representative:

Member Name: _____ SS# ____-____-____ Date of Birth _____

Spouse Name: _____ SS# ____-____-____ Date of Birth _____

Dependent Name: _____ SS# ____-____-____ Date of Birth _____

Dependent Name: _____ SS# ____-____-____ Date of Birth _____

Dependent Name: _____ SS# ____-____-____ Date of Birth _____

Dependent Name: _____ SS# ____-____-____ Date of Birth _____

Street _____

City_____ State:_____Zip Code:_____Telephone number (with area code): (___)_____

Section B: Individual that is being designated as the above family's personal representative:

Name_____PIN (four digit number) * _____

Street_____

City_____ State:_____ Zip Code:_____Telephone number (with area code): (___)_____

*** Your Personal Representative must assign a four-digit personal identification number. We will require that they identify themselves with this number before we will release Protected Health Information to them.**

Section C: Authorization:

We, hereby designate _____ as our (Choose **one**):
(Name of authorized representative)

A. _____ personal representative for **all** Protected Health Information.
B. _____ personal representative for only the following specific Protected Health Information:

_____

_____

Section D: Expiration:

This Authorization will expire (complete **one**): _____ Upon my termination from the health Plan

_____ On ____/____/_____

Member Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

Dependent Signature (If over Age 18): _____ Date: _____

Dependent Signature (If over Age 18): _____ Date: _____

Dependent Signature (If over Age 18): _____ Date: _____

Dependent Signature (If over Age 18): _____ Date: _____

Witness Signature: _____ Date: _____

Print Name: _____

YOU ARE ENTITLED TO A COPY OF THIS FORM