

## INDIANA LABORERS WELFARE FUND

P.O. BOX 1587 TERRE HAUTE, INDIANA 47808-1587 Telephone (812) 238-2551 Toll Free 1-800-962-3158 Fax (812) 238-2553 www.indianalaborers.org

## **Personal Representative Request**

This form is used to designate a personal representative for the individual identified in Section I, below. This form may be used by either:

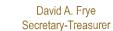
- The individual, who may designate a person to act on their behalf for services provided by Indiana Laborers Welfare Fund, [Complete Sections I, II, and III]. By designating a personal representative, the individual authorizes Indiana Laborers Welfare Fund to disclose any and all personal health information, unless limited by the authority to act, to the personal representative identified in Section II, below<sup>1</sup>. The individual may revoke a personal representative designation at any time by contacting Indiana Laborers Welfare Fund in writing.
   OR-
- A person who, under applicable law, has the authority to act on behalf of the individual in making
  decisions related to health care (e.g., health care power of attorney, health care proxy, courtappointed legal guardian, appointment as executor or administrator of deceased participant's
  estate) [Complete Sections I, II, and IV]. Appropriate legal documentation establishing a personal
  representative relationship with the individual, either by the individual or court-appointed, must
  accompany this completed form<sup>2</sup>.

Indiana Laborers Welfare Fund will use the information provided on this form to process your request. Unless informed otherwise, or if a legal exception applies, parents are the personal representatives of minor dependent(s)<sup>3</sup>.

A separate form is required for each Personal Representative designation.

SECTION I: Participant/Dependent Identification (please print):							
Name:							
First	Middle		Last				
Member ID or Social Security Number	per: Date of Birth:						
Address:Street		City	State	Zip			
Phone Number:	Ä						
<sup>1</sup> 45 CFR 164.524 <sup>2</sup> IC 16-36-1, IC 29-1-10, IC 30-5-4							







3 45 CFR 164.502(g), 45 CFR 164.522(a)

SECTION II: Personal Representative (please print):							
Name: First		 Middle		Last			
11130		Middle		Lust			
Date of birth:	MM DD	YYYY					
Relationship to	the Participant	/Dependent:					
Address:							
	Street		City	State	Zip		
Phone Number	SECTION III		 gnation of Perso	nal Representati	ve		
authorize India limited by the representative Fund. I underst held by Indiana plan information may have acce health, HIV, sex	na Laborers We e authority to , so that he or sl and that my per a Laborers Welfa on, and my enro ess to informatic xually transmitte	Ifare Fund to disclost act, to my persone may act on my be sonal representative are Fund including multiment information on regarding my treed diseases, substantically act of the sonal regarding my treed diseases, substantically are sonal regarding my treed diseases, substantically act of the sonal regarding my treed diseases, substantically act of the sonal regarding my treed diseases, substantically act of the sonal regarding my treed diseases, substantically act of the sonal regarding my treed diseases.	se any and all of open all representa ehalf for services will have full act on prescription road at ment for certaince abuse, and reconstants.	my personal heal tive, as request provided by Indicess to my personecords, my paymestand that my personecords in "sensitive coreproductive healt			
Laborers Welfa understand tha	re Fund written at the revocation	notice. However, if	I revoke this per action Indiana I	sonal representat -aborers Welfare	ime by giving Indiana tive designation, I also Fund took in reliance ce of revocation.		

I also understand that Indiana Laborers Welfare Fund will not condition treatment, payment, enrollment, or the eligibility for health plan benefits on this personal representative designation.

I also understand that if the person I designate as my personal representative is not subject to the Health Insurance Portability and Accountability Act ("HIPAA") or other health information privacy laws, he or she may further disclose my health information and it may no longer be protected by HIPAA or other health information privacy laws.

This personal representative designation expires on (enter date): \_\_\_\_\_/\_\_\_ MM DD YYYY (If no expiration date is provided, this designation is in effect until revoked in writing)

Signature:	Date:							
***This form must be submitted with a copy of the Participant's drivers license or other identificatio for signature verification purposes.								
SECTION IV	: Personal Representative Acknowledgment							
I. The information provided in Section undersigned as the personal representation of the legal document establishment.	r applicable law to act on behalf of the individual identified in Secon II should be used by Indiana Laborers Welfare Fund to identifientative of the individual in Section I. Please return with this fooling your status as personal representative for the individual identifience of Attorney, Court Order, etc.)	y the						
Signature:	Date:							