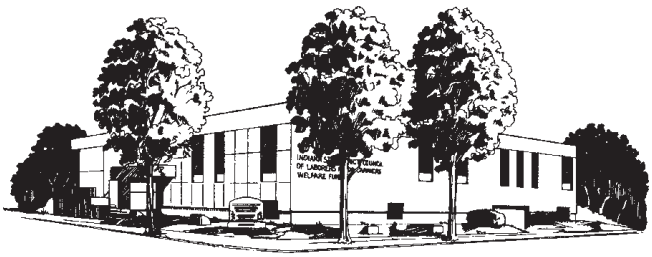

INDIANA LABORERS WELFARE FUND
P.O. BOX 1587 TERRE HAUTE, INDIANA 47808-1587
Telephone (812) 238-2551 Toll Free 1-800-962-3158
Fax (812) 238-2553 www.indianalaborers.org

Individual Request to Designate a Personal Representative

This form may be used to notify Indiana Laborers Welfare Fund of a personal representative for the individual identified in Section I, below. This form may be used by either:

- The individual, who may identify and designate a person to act on his or her 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 his or her health information to the personal representative identified in Section II, below. The individual may revoke a personal representative designation at any time by contacting Indiana Laborers Welfare Fund in writing.

- 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, court-appointed legal guardian, general power of attorney) [Complete Sections I, II, and IV]. Appropriate legal documentation establishing a personal representative relationship with the individual must accompany this completed form.

Indiana Laborers Welfare Fund will use the information provided on this form to properly process your request. Unless informed otherwise, parents are the personal representatives of minor dependent(s).

SECTION I: Participant/Dependent Identification (please print):

(A separate form is required for each individual.)

Name: _____
First Middle Last

Gender: ☐Male ☐Female Date of birth: _____ _____ _____
MM DD YYYY

Member ID number: _____ (or you may list your Social Security Number)

Address: _____
Street City State Zip

Telephone where we may contact you in case of questions: _____ -_____ - _____

SECTION II: Information about the Personal Representative (please print):

Name: _____
First Middle Last

Gender: ☐Male ☐Female Date of birth: _____ _____ _____
MM DD YYYY

Relationship to the Participant: ☐Spouse/partner ☐Other family member ☐Other nonfamily

Address: _____
Street City State Zip

Telephone where we may contact you in case of questions: _____ -_____ - _____

Section III: Participant's Designation of Personal Representative

I designate the person identified in Section II to serve as my personal representative. By doing so, I authorize Indiana Laborers Welfare Fund to disclose my health information to my personal representative, as requested by my personal representative, so that he or she may act on my behalf for services provided by Indiana Laborers Welfare Fund. I understand that my personal representative will have access to all of my personal health information held by Indiana Laborers Welfare Fund including my prescription records, my payment history, my health plan information, and my enrollment information. I further understand that my personal representative may have access to information regarding my treatment for certain "sensitive conditions" (e.g., mental health, HIV, sexually transmitted diseases, substance abuse, and reproductive health services).

I understand that I may revoke my personal representative designation at any time by giving Indiana Laborers Welfare Fund written notice. However, if I revoke this personal representative designation, I also understand that the revocation will *not* affect any action Indiana Laborers Welfare Fund took in reliance on this designation before Indiana Laborers Welfare Fund received my written notice 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 delegation is in effect until revoked in writing)

Signature _____ **Date**_____
(If under 18 must be signed by the Participant)

******This form must be submitted with a copy of the Participant's driver's license (or other identification) for verification of signature.**

A separate form is required for each individual.

Section IV: Personal Representative Notification of Status

The undersigned has authority under applicable law to act on behalf of the individual identified in Section I. The information provided in Section II should be used by Indiana Laborers Welfare Fund to identify the undersigned as the personal representative of the individual in Section I. Please return with this form a copy of the legal document establishing your status as personal representative for the individual identified in Section I (e.g., Health Care Proxy, Power of Attorney, Court Order, etc.).

_____ _____
Personal Representative Signature Date