Appointment of Representative

Medica

1. Member Information

Member Name: _____Date of Birth: (mo/day/year) _____/_____/_____

Mailing Address: _____City_____St___Zip_____-

Group/Policy #: IFB____ 10 Digit ID#:_____ Telephone Number: _____

Appointment of Representative

I hereby appoint the individual named below to act as my representative for the purpose indicated in this form. I understand that this individual will be my agent and is authorized to act on my behalf as I have indicated below:

❑ I hereby appoint the individual named below to act as my representative **for all purposes** related to my membership in my health benefit plan.

OR

❑ I hereby appoint the individual named below to act as my representative **for the following activity**:

Representative Name: _____

Mailing Address: _____

Telephone Number: _____

Relationship: _____

2. Personal Information

I understand that my personal medical information that is relevant to the matter for which the representative is appointed may be disclosed to the representative indicated above. This information may include all medical and pharmacy information and mental health and substance abuse information relevant to the purposes of this appointment. Once released, I understand that such information may no longer be protected by privacy laws and may be further disclosed by my representative without my authorization.

3. Revocation

I understand that this appointment will remain in effect until I revoke it. I may revoke this appointment at any time by providing written notice to the address below. However, I understand that my revocation will not affect any action taken, or any information already released, based upon this appointment before my request to revoke has been received.

4. **Member Signature**

I have fully read this form and hereby appoint the individual indicated above to act as my representative, subject to the terms and conditions of this form. I understand that my treatment, payment, enrollment, or eligibility for benefits is not affected by whether or not I sign this form.

Signature of Member*: _____ **Date**: _____

***If someone other than the member is signing this form on behalf of the member, please provide the name of such person, the relationship to the member, and a copy of legal authorization (e.g. power of attorney, legal guardian, foster parent).

Name of Person Signing for Member: _____

Relationship to Member: _____

Return completed form to:

Route CP595IFB
WellFirst Health
PO Box 9310
Minneapolis, MN 55440-9310

Or

Fax to: 952-992-2583