UFCW TRUST
Working For Your Benefit

Mail: P. O. Box 4100 · Concord, CA 94524-4100
Telephone: (800) 552-2400 · Facsimile: (925) 746-7549
www.ufcwtrust.com

APPOINTMENT OF PERSONAL REPRESENTATIVE FORM

(Please Print)

I. Information Regarding Participant or Beneficiary

I, _____
(Name of Participant or Beneficiary)

Mailing Address: _____

Social Security Number: _____

Date of Birth: _____ Phone: _____

II. Designation of Personal Representative for Participant/Beneficiary

☐ Hereby designate: _____
(Name of Personal Representative)

to act on my behalf.

I authorize my Personal Representative to receive or change any Participant, Dependent or Beneficiary information, including but not limited to contact information, election changes, information that relates to my claim for coverage or benefits under the Plan, and any individual rights that I have regarding my protected health information under HIPAA (Health Insurance Portability and Accountability Act of 1996).

Personal Representative's
Relationship to Participant/Beneficiary: _____

III. Designation of Personal Representative for Dependent

(This designation may be made by a parent or guardian of a minor, or by the guardian or conservator of an adult individual)

☐ Hereby designate: _____
(Name of Personal Representative)

to act on behalf of: _____
(Name of Dependent)

I authorize my Dependent's Personal Representative to receive any information that is (or would be) provided to me as a Participant/Beneficiary of the Plan regarding my Dependent, including but not limited to, any information that relates to a claim for coverage or benefits under the Plan and any individual rights that I have regarding my Dependent's protected health information under HIPAA. I understand that under state law, there are circumstances in which a minor child's protected health information cannot be released to a parent, or to a Personal Representative acting on a parent's behalf.

Dependent's
Relationship to
Participant/Beneficiary: _____

Personal Representative's
Relationship to Participant/Beneficiary: _____

Dependent's Mailing address:_____

Dependent's Social Security Number:_____

Dependent's Date of Birth:_____

Dependent's Phone: (_____)_____

IV. Information Regarding the Personal Representative

Mailing Address: _____

Social Security Number: _____

Date of Birth:_____

Phone: (_____)_____

V. Statement of Individual Rights

I understand that this designation is subject to approval by the Plan. I also understand that, once approved, this designation will remain in effect unless I revoke it. I understand that I have the right to revoke this designation at any time by submitting a signed statement to that effect to the UFCW & Employers Trust, LLC Office at P.O. Box 4100, Concord, CA 94524-4100.

I also understand that Dependents may have their own rights by law and that one member of a family may not always have the authority to authorize the uses or disclosures of the protected health information of other family members.

VI. Signatures:

_____ _____
Participant or Beneficiary's Signature Date

_____ _____
Personal Representative's Signature Date