Designation of Authorized Representative

I, _____ do hereby appoint _____
Member Name — Facility or Person who is authorized to appeal on Members behalf

(hereafter "my Authorized Representative) to act on my behalf in pursuing a benefit claim, specifically:

_____
Benefit/Claim that is being appealed

My Authorized Representative shall have full authority to act, and receive notices, on my behalf with respect to an adverse benefit determination of the claim, any request for documents relating to the claim, and any appeal of an adverse benefit determination of the claim.

I understand that in the absence of the contrary direction from me, (the "Plan") will direct all information and notices regarding the Claim to which I otherwise am entitles, including benefit determination, to my Authorized Representative only.

I also understand that I am giving my Authorized Representative the rights to use and exhaust the appeal levels, for this claim, that I have under the Plan.

I am aware that the Standards for Privacy of Individually Identifiable Health Information set forth by the U.S. Department of Health and Human Services (the "Privacy Standards") governs access to medical information. I understand that in connection with the performance of his/her duties hereunder, my Authorized Representative may receive my Protected Health Information, as defined in the Privacy Standards, relating to the Claim. I hereby consent to any disclosure of my Protected Health Information to my Authorized Representative.

X _____ X _____
Signature of Claimant — Date

Acknowledgement

I, _____ have read the above Designation of Authorized Representative statement and hereby accept this designation and agree to act as Authorized Representative for _____ with respect to the claim.

X _____ X _____
Signature of Authorized Representative — Date

Please Return with Appeal Request Form, and any additional clinical documents, doctor's notes relevant to the Claim that is being appealed