Designation of Authorized Representative

I, _____ do hereby appoint _____ (hereafter "my Authorized Representative) to act on my behalf in pursuing a benefit claim, specifically, _____

_____(the "Claim"). My Authorized Representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the Claim, any request for documents relating to the Claim, and any appeal of an adverse determination of the Claim.

I understand that in the absence of a contrary direction from me, (the "Plan') will direct all information and notices regarding the Claim to which I otherwise am entitled, 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 U.S. Department of Health and Human Services (the "Privacy Standards") govern 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.

Date _____ Signature of Claimant _____

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 defined above.

Date _____ Signature of Representative _____