APWU Health Plan
Designation of Personal Representative

With this form, you are designating a personal representative to act on your behalf in making health care payment related decisions through APWU Health Plan. The individual you name as your personal representative can be a family member, friend, attorney or unrelated party and will have access to your protected health information (PHI), including diagnoses, medical procedures, medications, treating providers, and information such as your date of birth and address. To designate a personal representative, you must complete, sign, date, and submit this form to APWU Health Plan. This designation will become effective once it has been entered into our systems, typically within 15 calendar days of receipt.

Please print neatly to ensure accurate processing and to avoid delays in service.

1. Requestor Information:

Requestor ID #: _____

First Name: _____ MI: _____

Last Name: _____ Date of Birth: _____ / _____ / _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____

E-mail Address: _____

2. At my request, I designate the following individual to be my Personal Representative:

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____

E-Mail Address: _____

3. **This designation will expire two (2) years after your coverage at the APWU Health Plan ends, unless you notify APWU Health Plan otherwise.**

4. **Right to Revoke (Cancel):**

I understand that I may revoke this designation at any time by sending a letter to the APWU Health Plan. Revoking this designation will not affect any action that the APWU Health Plan took prior to receiving the written notice of revocation. The revocation should be sent to the APWU Health Plan, HIPAA Privacy/Security Specialist, 799 Cromwell Park Drive, Suites K-Z, Glen Burnie, MD 21061.

Please refer to the Notice of Privacy Practices, available at **www.APWUHP.com**, for information pertaining to your opportunity to revoke an authorization, as well as the exceptions to this right. Also in the Notice of Privacy Practices is an explanation of all other available rights under the Privacy Rule.

5. **Signature:**

I understand that this designation is voluntary and being made at my request. I have had the full opportunity to read and consider the contents of this designation, and I confirm that the information is consistent with my direction to APWU Health Plan. I understand that by signing this form, I am giving my authorization to APWU Health Plan to communicate with my designated Personal Representative acting on my behalf in making healthcare payment related decisions.

Signature: _____ **Date:** _____

6. **Please mail this Designation of Personal Representative to:**

APWU Health Plan
HIPAA Privacy/Security Specialist
799 Cromwell Park Drive; Suites K-Z
Glen Burnie, MD 21061

1-800-222-2798

Please keep a copy of this designation for your records.
We will provide you with a signed copy of this designation at your request.