KENTUCKY LABORERS DISTRICT COUNCIL HEALTH & WELFARE FUND
1996 Bypass South
Lawrenceburg, KY 40342

Telephone: (502) 839-8166 **FAX: (502) 839-3558**

APPOINTMENT OF PERSONAL REPRESENTATIVE

(Authorization to Disclose Information to Participant's or Beneficiary's Appointed Personal Representative)

I, ____ ___________________________________
(Name of Participant or Beneficiary) **(Soc. Sec. # of Participant or Beneficiary)**

Mailing Address of Above Individual:____
(Street or P.O. Box) **(City)** **(State)** **(Zip)**

Phone Number of Above Individual: (_____)______________________ Date of Birth:_____________________

HEREBY DESIGNATE: ____ ___________________________________
(Name of Personal Representative) **(Personal Representative's Date of Birth)**

Mailing Address of Personal Representative: ____
(Street or P.O. Box) **(City)** **(State)** **(Zip)**

Phone Number of Personal Representative: (_____)____________________________________
Relationship to Participant or Beneficiary: ____

TO ACT ON MY BEHALF, AND ON BEHALF OF THE FOLLOWING COVERED DEPENDENT[S]:

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[**Note: If Covered Spouse and/or Covered Children are named, Covered Spouse must also sign this authorization.]**

CHECK (√) ONE OF THE FOLLOWING:

_____1. I authorize my Personal Representative to act for me [or for above-named dependents] in receiving any information that is (or would be) provided to me as a Participant/Beneficiary of the Fund, including but not limited to, **ANY** information that relates to my claim for coverage or benefits under the Fund and any individual rights that I have regarding my protected health information under HIPAA, or,

____ 2. I authorize my Personal Representative to act for me [or for above-named dependents] in receiving any information that is (or would be) provided to me as a Participant/Beneficiary of the Fund, **ONLY** information that is (or would be) provided to me as a Participant/Beneficiary of the Fund regarding my eligibility status, hours/contributions reported on my behalf, employers who have reported on my behalf and/or self payments I have made to continue coverage.

____ 3. I authorize my Personal Representative to act for me [or for the above-named dependents] in receiving the following protected health information to conduct the following functions on my behalf: **[PLEASE LIST THE INFORMATION THAT MAY BE DISCLOSED TO YOUR PERSONAL REPRESENTATIVE]**

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I understand that this designation is subject to approval by the Fund. 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 Fund Office.

______________________________	______________________________	____________________
(Participant's or Beneficiary's Signature)	**(Participants / Beneficiary's Date of Birth)**	**(Date Signed)**
______________________________	______________________________	____________________
(Dependent Spouse's Signature)	**(Participants / Beneficiary's Date of Birth)**	**(Date Signed)**
______________________________	______________________________	____________________
(Authorized Personal Representative's Signature)	**(Auth. Personal Representative's Date of Birth)**	**(Date Signed)**