



ASSOCIATED BENEFITS CORPORATION

AUTHORIZED REPRESENTATIVE APPOINTMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

Employee/Participant Name: ID Number: Claimant/Patient Name: Street Address: City, State, Zip: Phone Number: Group Name or Number:

I appoint the individual named below to act on my behalf as my Authorized Representative with Associated Benefits Corporation in connection with (please check all appropriate boxes below)

- my inquiries and claims for health care benefits with the dates of service (specify);
all my claims or inquiries for health care benefits on and after the effective date of this appointment;
my appeal of denied claim(s) with the date(s) of service (specify):

This appointment of Authorized Representative is effective upon Associated Benefits Corporation's receipt of a fully completed and signed original, or exact copy of this form at the address stated below.

I authorize the release and disclosure of any and all personal health information, including specifically mental health information, substance abuse (drug or alcohol), and AIDS-related information, if applicable, and all claims information to the individual named below as long as this appointment of Authorized Representative is in effect.

REDISCLOSURE: Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (48 C.F.R. Part 2) and any state requirements prohibiting further disclosure without the specific written consent of the person to whom it pertains...

I acknowledge that information to be released may include material that is protected by state and/or federal law applicable to mental health or other information. My signature authorizes the release of all such information as specified above.

Participant's Signature (or Legal Guardian if applicable) Date

Printed Name of Legal Guardian (if applicable)

IMPORTANT PLEASE CAREFULLY REVIEW AND SIGN THIS FORM. SIGNATURES ARE REQUIRED ON BOTH PAGES OF THIS FORM! (SIGNATURES ARE REQUIRED ON BOTH PAGES OF THIS FORM)

TO BE COMPLETED BY AUTHORIZED REPRESENTATIVE

ACCEPTANCE OF APPOINTMENT

I accept the appointment as the Authorized Representative as stated on page one of this form.

Signature **Date**

Name: _____
Street Address: _____
City, State, Zip: _____
Phone Number: _____

Send completed and signed form to:

Associated Benefits Corporation
Attn: Privacy Office
P.O. Box 71039
Des Moines, Iowa 50325

(Retain a copy for your records.)

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FOR ASSOCIATED BENEFITS CORPORATION USE ONLY:

DATE RECEIVED: \_\_\_\_\_