MEDICAL BENEFITS MUTUAL LIFE INSURANCE CO.
MEDICAL BENEFITS ADMINISTRATORS, INC.
VISIONPLUS OF AMERICA, INC.
("MedBen")

NOTIFICATION AND AUTHORIZATION OF PERSONAL REPRESENTATIVE FORM

The federal HIPAA Privacy Rules, and other federal and state regulations on privacy and confidentiality, allow you the right to request MedBen to speak with and otherwise communicate with individuals, family members, and friends that you designate as your personal representative(s). MedBen must treat your personal representative(s) just as if the personal representative(s) were you, unless you've restricted the authority of the personal representative(s), as you've describe in the space provided below. For instance, a personal representative can sign authorizations for disclosure of individually identifiable and protected health information (PHI) on your behalf. Likewise, MedBen can disclose PHI directly to your personal representative.

In order to for a personal representative to represent you, you must complete the form below and authorize MedBen to treat the individual as your personal representative. Your personal representative must be able, under applicable law, to act on your behalf in making decisions for you regarding your coverage under the health benefits plan(s) listed below. This means that your personal representative must be able to provide us with documentation supporting his or her status as your personal representative for purposes of your health benefit plan(s). This documentation can include, but is not limited to, a power of attorney specifically giving your personal representative for the purposes of the HIPAA Privacy Rules.

In order to appoint and authorize a personal representative, please complete the information below and either describe your personal representative's authority or attach documentation of such authority to this form. You will be notified when your request has been approved or denied.

The undersigned hereby requests that the following individual be designated as my personal representative for purposes of my coverage under the health benefit plan(s) listed below. I understand that I have the right to terminate the authority of this personal representative, by sending such a request in writing to MedBen's Chief Privacy Officer at the address set forth below.

Print Your Name: _____

Provide Your MedBen Personal Identification Number: _____

Print Name of Designated Personal Representative: _____

List the applicable Health Benefit Plan(s):

_____

_____

_____

List any exceptions to the authority you are giving your Personal Representative. If no exceptions are to be made regarding the information we can share with your Personal Representative, check the box marked “No Exceptions” below.

☐ No Exceptions

Please make a statement below supporting your assertion that the Personal Representative listed is entitled to act as your personal representative. If you have documentation supporting your request please attach it to this authorization. In addition, supply any additional information we need to render a decision regarding the validity of the documentation and its authority under applicable law.

By signing below, I hereby authorize MedBen to appoint and individual listed above as my Personal Representative until such time as I terminate this authorization in writing.

Print Name of Covered Person

Covered Person’s Signature & Date Signed

MedBen
Chief Privacy Officer
1975 Tamarack Road
Newark, Ohio 43055
(800) 423-3151
(740) 522-8425