LOCAL 15
A,C,D WELFARE FUND

HIPAA
DESIGNATION FORM

I.U.O.E. LOCAL 15

A, C, D WELFARE FUND

Dear Plan Participant

In accordance with the Health Insurance Portability and Accountability Act of 1996, (commonly called HIPAA) if you wish the Welfare Fund of the International Union of Operating Engineers, Local 15, 15A, 15C and 15D, to speak to someone other than you concerning your medical claims, etc., you must complete the attached documents.

Conversely, if your spouse or child over the age 18 years wishes you or some other person to speak to the Welfare Fund Office and it's Administrator concerning their medical claims etc., they too will also need to complete the authorization form. If you have more than two adult children (18 and over), please duplicate the requesetd information on an additional piece of paper.

Information concerning how your medical information may be used and disclosed can be found under the title of "Notice of Privacy Practice" in the "Other Plan Information" section of the Welfare Fund Summary Plan Description Book. Please read that section carefully.

Lastly, the Fund has the right to require you to complete this document from time to time and as often as it determines reasonably necessary to maintain current records. The Welfare Fund will provide you with signed confirmation attesting to the receipt of this document. If you do not receive this verification, it means the Welfare Fund never received your HIPAA Form.

HIPAA Designation for the Member/Participant

(Please Print)

I, ____ SS#_____ - ____ - _______
(Member/Participant Name)

Hereby designate ____ to act on my behalf to
(Designated Representative Name(s))

pursue any claims for coverage or benefits, including receipt of any approvals or authorizations that are required before benefit services are provided under the Welfare Fund of the International Union of Operating Engineers, Local 15, 15A, 15C and 15D.

I authorize the aforementioned individual to receive any and all information that would be provided to me, and to act for me, in providing any information to the plan that relates to any claim for coverage or benefits under the plan.

Member/Participant Signature ___________________________________ Date _______________

I, by signing below, hereby accept the assignment of Designated Representative for the above named claimant.

Designated Representative Signature(s) ____

Relation to Member/Participant: ____

Mailing Address of Designated Representative(s): _______________________________________

____

Telephone # of Designated Representative(s): ______________________________

HIPAA Designation for the Spouse

(Please Print)

I, ______________________________________ SS#_____ - ____ - ______

(Spouse Name)

Hereby designate ___________________________________to act on my behalf to pursue

(Designated Representative Name(s))

any claims for coverage or benefits, including receipt of any approvals or authorizations that are required before benefit services are provided under the Welfare Fund of the International Union of Operating Engineers, Local 15, 15A, 15C and 15D.

I authorize the aforementioned individual to receive any and all information that would be provided to me, and to act for me, in providing any information to the plan that relates to any claim for coverage or benefits under the plan.

Signature of Spouse ___________________________________ Date ____________

I, by signing below, hereby accept the assignment of Designated Representative for the above named claimant.

Designated Representative Signature(s) ___________________________________

Relation to Member/Participant: ___________________________________

Mailing Address of Designated Representative(s): ___________________________________

____

Telephone # of Designated Representative(s): ___________________________

HIPAA Designation for Dependent Child 18 Years or Older

(Please Print)

I, ______________________________________ SS#_____ - ____ - ______

(Child's Name)

am the dependent of ___________________________, and as such, hereby designate

(Member/Participant's Name)

___________________________________to act on my behalf to pursue any claims for cover-

(Designated Representative Name(s))

age or benefits, including receipt of any approvals or authorizations that are required before benefit services are provided under the Welfare Fund of the International Union of Operating Engineers, Local 15, 15A, 15C and 15D.

I authorize the aforementioned individual to receive any and all information that would be provided to me, and to act for me, in providing any information to the plan that relates to any claim for coverage or benefits under the plan.

Signature of Child ___________________________________ Date ____________

I, by signing below, hereby accept the assignment of Designated Representative for the above named claimant.

Designated Representative Signature(s) ___________________________________

Relation to Member/Participant: ___________________________________

Mailing Address of Designated Representative(s): ___________________________________

____

Telephone # of Designated Representative(s): ___________________________

HIPAA Designation for Dependent Child 18 Years or Older

(Please Print)

I, ____ SS#_____ - _____ - _______
(Child's Name)

am the dependent of ____________________________________, and as such, hereby designate
(Member/Participant's Name)

____ to act on my behalf to pursue any claims for cover-
(Designated Representative Name(s))

age or benefits, including receipt of any approvals or authorizations that are required before benefit services are provided under the Welfare Fund of the International Union of Operating Engineers, Local 15, 15A, 15C and 15D.

I authorize the aforementioned individual to receive any and all information that would be provided to me, and to act for me, in providing any information to the plan that relates to any claim for coverage or benefits under the plan.

Signature of Child ____ Date _______________

I, by signing below, hereby accept the assignment of Designated Representative for the above named claimant.

Designated Representative Signature(s) ____

Relation to Member/Participant: ____

Mailing Address of Designated Representative(s): ______________________________________

____

Telephone # of Designated Representative(s): ________________________________

For Office Use Only

Date Received: __________________________ Date Entered: __________________________

Name of Individual Entering Information: ____

Date Mailed Back to Participant: ____

Form Was Deemed: ❑ Complete ❑ Incomplete

Comments: ____

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Signed: ____ Date: _______________