ROOFERS LOCAL 195 HEALTH AND ACCIDENT FUND

APPOINTMENT OF PERSONAL REPRESENTATIVE

This document gives the person whom you designate ("Your Personal Representative") broad powers to receive information and act on your behalf. If you do not understand this document, you should ask a lawyer to explain it to you.

All information on the form must be provided and you must initial the form where indicated. If you fail to do so, this form will be rejected and the Fund will not honor your appointment.

Name of individual appointing personal representative: _____
Address of individual appointing personal representative: _____
_____

Phone number: ( ) _____
Date of birth: _____
Social Security number: _____

Name, Address and Social Security Number of Plan Participant: _____
_____

Relationship of individual making appointment to Plan Participant: _____
_____

Phone number of Plan Participant: ( ) _____

I hereby designate the following person as my personal representative (name and address):
_____
_____
_____

Phone number of personal representative: ( ) _____

Relationship of personal representative to individual making the appointment: _____

To indicate the scope of your personal representative's authority, please check the applicable box:

□ I hereby authorize the above named Personal Representative to exercise any rights that I may exercise as a participant or beneficiary of the Fund under the Health Insurance Portability and Accountability Act of 1996 ["HIPAA"] concerning my "protected health information" ["PHI"], including: (1) any and all physical or mental health conditions (past, present or future); (2) the provision of health care to me; or (3) payment for the provision of health care to me (past, present or future). Such authority includes, but is not limited to, the right to copy and inspect my PHI, to amend my PHI, to request confidential communications, to an accounting of disclosures of my PHI, and to make health care payment decisions for me, including resolving benefit claim matters on my behalf and authorizing other uses and disclosures of my PHI. **There are no restrictions on the type of information that may be received by my Personal Representative.**

□ I hereby restrict the scope of my Personal Representative's authority and access to my "protected health information" ["PHI"]. I hereby authorize my personal representative to act for me only in having access to the following PHI to conduct the following functions on my behalf (identify PHI and purpose for which personal representative may use PHI):

_____

_____

_____

_____

_____

This appointment is of unlimited duration until revoked by me.

Initials: _____

OR

This appointment will expire on _____

Initials: _____

You must select one of the following options:

□ This appointment shall continue to be effective even if I become disabled, incapacitated or incompetent.

□ This appointment shall cease to be effective if I become disabled, incapacitated or incompetent.

This appointment is subject to the Plan's approval. If approved, this appointment will remain in effect unless revoked by me. This appointment is voluntary and I have the right to refuse to grant the appointment. It may be revoked by me at any time by notifying the Fund Office in writing. If I have appointed my spouse as personal representative, the appointment will be revoked upon our divorce or legal separation. The revocation is only effective after notice of revocation is received by the Fund Office and it will not effect any actions or disclosures by the Fund Office based on this form and prior to receipt of the revocation. I understand that after my PHI is disclosed to the person or organization appointed as my personal representative, they may not treat my PHI as confidential and may re-disclose it.

Date: _____

Signature:_____

Individual

On the _____ day of _____, before me personally came _____ to be known, known to me, to be the individual described in and who executed the foregoing instrument and he acknowledged to me that he executed the same.

_____

Notary Public