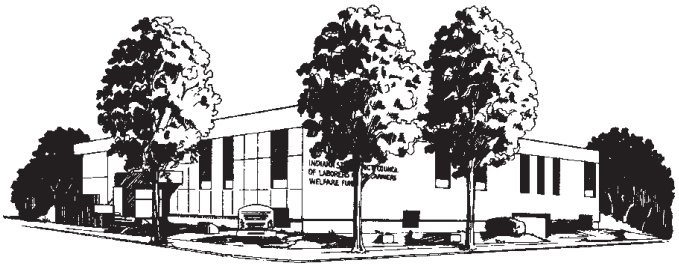

INDIANA LABORERS WELFARE FUND
P.O. BOX 1587 TERRE HAUTE, INDIANA 47808-1587
Telephone (812) 238-2551 Toll Free (800) 962-3158
Fax (812) 238-2553 www.IndianaLaborers.org

LEGAL REPRESENTATIVE REQUEST

This form is used to designate a personal representative for the individual identified in Section I, below. This form may be used by either:

- The individual, who may designate a person to act on their behalf for services provided by Indiana Laborers Welfare Fund, [Complete Sections I, II, and III]. By designating a personal representative, the individual authorizes Indiana Laborers Welfare Fund to disclose any and all personal health information, unless limited by the authority to act, to the personal representative identified in Section II, below[1]. The individual may revoke a personal representative designation at any time by contacting Indiana Laborers Welfare Fund in writing.

  -OR-
- A person who, under applicable law, has the authority to act on behalf of the individual in making decisions related to health care (e.g., health care power of attorney, health care proxy, court-appointed legal guardian, appointment as executor or administrator of deceased participant's estate) [Complete Sections I, II, and IV]. Appropriate legal documentation establishing a personal representative relationship with the individual, either by the individual or court-appointed, must accompany this completed form[2].

Indiana Laborers Welfare Fund will use the information provided on this form to process your request. Unless informed otherwise, or if a legal exception applies, parents are the personal representatives of minor dependent(s)[3].

A separate form is required for each Personal Representative designation.

SECTION I: Participant/Dependent Identification (please print):

Name: _____
First Middle Last

Date of birth: _____
MM DD YYYY

Member ID or Social Security Number: _____

Address: _____
Street City State Zip

Phone Number: _____ -_____ - _____

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[1] 45 CFR 164.524
[2] IC 16-36-1, IC 29-1-10, IC 30-5-4
[3] 45 CFR 164.502(g), 45 CFR 164.522(a)

SECTION II: Personal Representative (please print):

Name: _____
First Middle Last

Date of birth: _____
MM DD YYYY

Relationship to the Participant/Dependent: _____

Address: _____
Street City State Zip

Phone Number: _____ -_____ - _____

SECTION III: Participant's Designation of Personal Representative

I designate the person identified in Section II to serve as my personal representative. By doing so, I authorize Indiana Laborers Welfare Fund to disclose any and all of my personal health information, unless limited by the authority to act, to my personal representative, as requested by my personal representative, so that he or she may act on my behalf for services provided by Indiana Laborers Welfare Fund. I understand that my personal representative will have full access to my personal health information held by Indiana Laborers Welfare Fund including my prescription records, my payment history, my health plan information, and my enrollment information. I further understand that my personal representative may have access to information regarding my treatment for certain "sensitive conditions" (e.g., mental health, HIV, sexually transmitted diseases, substance abuse, and reproductive health services).

I understand that I may revoke my personal representative designation at any time by giving Indiana Laborers Welfare Fund written notice. However, if I revoke this personal representative designation, I also understand that the revocation will *not* affect any action Indiana Laborers Welfare Fund took in reliance on this designation before Indiana Laborers Welfare Fund received my written notice of revocation.

I also understand that Indiana Laborers Welfare Fund will not condition treatment, payment, enrollment, or the eligibility for health plan benefits on this personal representative designation.

I also understand that if the person I designate as my personal representative is not subject to the Health Insurance Portability and Accountability Act ("HIPAA") or other health information privacy laws, he or she may further disclose my health information and it may no longer be protected by HIPAA or other health information privacy laws.

This personal representative designation expires on (enter date): _____/_____/_____ MM DD YYYY
(If no expiration date is provided, this designation is in effect until revoked in writing)

Signature: _____ Date: _____

*****This form must be submitted with a copy of the Participant's driver's license or other identification for signature verification purposes.**

SECTION IV: Personal Representative Acknowledgment

The undersigned has authority under applicable law to act on behalf of the individual identified in Section I. The information provided in Section II should be used by Indiana Laborers Welfare Fund to identify the undersigned as the personal representative of the individual in Section I. Please return with this form a copy of the legal document establishing your status as personal representative for the individual identified in Section I (e.g., Health Care Proxy, Power of Attorney, Court Order, etc.)

Signature: _____ Date: _____