

INDIANA LABORERS WELFARE FUND

P.O. BOX 1587 TERRE HAUTE, INDIANA 47808-1587 Telephone (812) 238-2551 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, below¹. 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 form².

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.

		SECT	TION I: Pa	rticipant/De	ependent Iden	tification (please	print):
Name: First				Middle		 Last	
Date of birth:							
Member ID or S	MM Social S	DD	YYYY Number:				
Address:		·					
	Street				City	State	Zip
Phone Number	:				-		

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		
FIISt	Middle		LdSl		
Date of birth: MM DD	YYYY				
Relationship to the Participant	/Dependent:				_
Address:Street		City	State	Zip	_
Phone Number:					
SECTIO	ON III: Participant's D	esignation of P	ersonal Represe	entative	
act, to my personal representation behalf for services provided by have full access to my personal records, my payment history, that my personal representation conditions" (e.g., mental heal services). I understand that I may revolute Welfare Fund written notice. He the revocation will not affect a	y Indiana Laborers W I health information h my health plan infor ive may have access th, HIV, sexually tra- ke my personal repre- dowever, if I revoke t	delfare Fund. I unteld by Indiana I mation, and months to information insmitted disease this personal repairs.	nderstand that radiorers Welfare y enrollment information at any tipe or search and the control of the control	my personal representation. I further reatment for cert buse, and reprocing the by giving Indignation, I also ur	esentative will ny prescription er understand tain "sensitive ductive health liana Laborers nderstand that
Indiana Laborers Welfare Fund					,
I also understand that Indiana eligibility for health plan benef				t, payment, enro	llment, or the
I also understand that if the pe Portability and Accountability A my health information and it n	Act ("HIPAA") or othe	r health informa	ition privacy laws	s, he or she may fu	urther disclose
This personal representative d (If no expiration date is provide					,
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 authori	ty under applicable law to act on behalf of the individual identified in Section I. The
information provided in Secti	on II should be used by Indiana Laborers Welfare Fund to identify the undersigned as
the personal representative of	of the individual in Section I. Please return with this form a copy of the legal document
establishing your status as pe	rsonal representative for the individual identified in Section I (e.g., Health Care Proxy,
Power of Attorney, Court Orc	er, etc.)
Signature:	Date: