insuringsmiles.com
PO Box 659 Evansville, IN 47704-0659
800-727-1444 Fax: 812-424-2096

PERSONAL REPRESENTATIVE DESIGNATION FORM

This form will allow me, as a HRI Dental & Vision group plan participant ("Plan"), to designate another person as my Personal Representative to act on my behalf in discussing my health information and benefit coverage through my Plan. When it has been verified that an individual has authority under applicable state and/or other applicable law to act as the Personal Representative of a Plan participant, the Plan will treat that person as the Plan participant with respect to the disclosure of Protected Health Information ("PHI") and the Plan participant's rights under the HIPAA Privacy Rule. When the Personal Representative authority ends, the Plan participant will need to contact the Privacy Officer in writing.

1. Required Information

PLAN PARTICIPANT	**Complete the information or check one box**	
Name:		
11-digit Member ID		
Date of Birth (MM-DD-YYYY):		
Address **City, State, ZIP**		
Type of Plan Participant:	☐ Employee / Subscriber ☐ Spouse / Partner	☐ Dependent Over 18 ☐ Dependent Under 18, Reason _____

PERSONAL REPRESENTATIVE		
Name:		
11-digit Member ID or Last 4 Digits of SSN		
Date of Birth (MM-DD-YYYY):		
Address **City, State, ZIP**		
Relationship to Plan Participant:	☐ Parent ☐ Spouse / Partner	☐ Dependent ☐ Other _____

2. Required Signatures

By signing this form, I hereby authorize the Plan to disclose information on my behalf in discussing my health information and benefit coverage through the Plan. Release of information to a Personal Representative will not occur if this form is incomplete.

Plan Participant Signature: **Date:**

Policyholder Signature (required in event that Plan Participant is a minor) **Date:**

Personal Representative Signature: **Date:**

Personal Representative Designation will remain in effect until such time that this appointment is revoked in writing to the address listed below:

HRI Dental & Vision
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Evansville, IN 47704-0659