New Paltz United Teachers Benefit Trust Fund

Personal Representative

Appointment of a Personal Representative

You must have an Appointment of Personal Representative Form on file in order for inquires to be made relative to your coverage or that of a dependent. As of April 14, 2004, if you or a covered dependent is over age 18, we CANNOT respond to any inquiry unless you and/or your dependent authorize a personal representative to inquire on behalf of you or your dependent. You may inquire about your dependents that are UNDER age 18.

Enclosed are Appointment of a Personal Representative Forms, please note

** You are the MEMBER on ALL FORMS, as the account is under your name

The INDIVIDUAL is your dependent, domestic partner or other individual of your choice.

Signatures must match the positions above.

Member’s signature followed by your Personal Representative’s signature

Or

Individual’s signature followed by his/her Personal Representative’s (which may be you)

It is wise for you to be the personal representative for your dependents and for at least one of them or someone that is close to you to be your personal representative, just in case you become disabled.

See attached forms

New Paltz United Teachers Benefit Trust Fund

Appointment of Personal Representative

Appointment of Personal Representative - FOR THE MEMBER

Member Name: _____ Phone ( ) _____

Member address: _____ City: _____ State: _____

Name and address of individual completing form (if other than member) Name: _____

Address _____ City _____ State _____ Zip _____ Phone _____

I hereby designate the following person as my personal representative: Relationship to MEMBER _____

Name _____Address _____

City _____ State _____ Zip _____Phone _____

I hereby authorize the above named personal representative to act for me in receiving any protected health information that may be provided to me as a participant or beneficiary of the Plan.

Or

I hereby authorize my personal representative to act for me in receiving the following protected health information to conduct the following functions on my behalf: _____

_____

I understand that this appointment is subject to the plan's approval. If approved, this appointment will remain in effect unless revoked. I understand that I have the right to revoke this appointment at any time by submitting to the Plan, in writing, a statement indicating that intent.

Signature of Member _____ Date _____

Signature of Personal Representative _____ Date _____

New Paltz United Teachers Benefit Trust Fund

Appointment of Personal Representative

Appointment of Personal Representative - FOR OTHER THAN THE MEMBER

Member Name: _____ Phone ( ) _____

Member address: _____ City: _____ State: _____

Name and address of **individual** completing form (if other than member) Name: _____

Address _____ City _____ State _____ Zip _____ Phone _____

I hereby designate the following person as my personal representative: Relationship to INDIVIDUAL_____

Name _____Address _____

City _____ State _____ Zip _____Phone _____

I hereby authorize the above named personal representative to act for me in receiving any protected health information that may be provided to me as a participant or beneficiary of the Plan.

Or

I hereby authorize my personal representative to act for me in receiving the following protected health information to conduct the following functions on my behalf: _____

_____

I understand that this appointment is subject to the plan's approval. If approved, this appointment will remain in effect unless revoked. I understand that I have the right to revoke this appointment at any time by submitting to the Plan, in writing, a statement indicating that intent.

Signature of Individual _____ Date _____

Signature of Member _____ Date _____