APPOINTMENT OF AUTHORIZED REPRESENTATIVE FORM

I, _____
[Name of Claimant]

Mailing address: _____

_____

Phone number:(_____)_____

Hereby appoint: _____
[Name of Authorized Representative]

Mailing address: _____

_____

Phone: (_____)_____

Relationship to claimant:_____

To represent the following Represented Individuals as indicated below: (Please check all that apply)

Represented Individuals

☐ Me ☐ My Spouse

☐ My Eligible Dependent(s) Whose Name(s) is/are:
_____

_____

Scope of Appoint

☐ in connection with ALL future claims for coverage or benefits under the Fund, including providing information to and receiving information from the Fund, until I revoke this authorization.

☐ in connection with _____ [Describe scope of the appointment (*e.g.*, date of service, claim amount service provider, etc.)]

_____

Claimant's Signature [Required] Date

_____

Spouse's Signature [If appointment covers your spouse] Date