UFCW LOCAL 1262 AND EMPLOYERS PENSION FUND
1389 Broad Street, Clifton, NJ 07013
Tel. (973) 778-5800 or (800) 522-4161

APPOINTMENT AND AUTHORIZATION OF PERSONAL REPRESENTATIVE

I. Participant / Beneficiary Information	I, ____ (Name of Participant or Beneficiary) Mailing Address: ____________________________________ ____ Telephone Number: __________________ SSN: ______________________ Date of Birth: ______________
II. Designation of Personal Representative	☐ hereby designate: ______________________________________ (Name of Personal Representative) to act on my behalf.
III. Personal Representative Information	Personal Representative Mailing Address: _______________________ ____ Telephone Number: ____________________ Relationship to Participant or Beneficiary: __________________________
IV. Authorization to Disclose Information	You have the right to appoint a Personal Representative to act on your behalf to receive information relating to your benefits, either generally or for specific purposes. Please check the box that applies to this authorization: ☐ I authorize my Personal Representative to act for me to access, amend, copy, receive and discuss all of my information relating to my entitlement to benefits from the Fund, including protected health information that may be protected from disclosure under the HIPAA Privacy rules. This appointment shall be effective until I notify the Fund in writing, to end the authorization. ☐ I authorize the Fund to disclose to my Personal Representative only the following specific information or protected health information: ____ ____ I understand that after this information is used or disclosed pursuant to this authorization, federal law may not protect it and the Personal Representative may disclose it again. I further understand that I have the right to seek assurances from the Personal Representative that s/he will not redisclose the information to any other party without my express additional authorization to do so. This authorization will expire (1) upon the termination of my participation in the Fund; (2) if I have authorized disclosure to my spouse, upon the dissolution of marriage; (3) when I revoke the authorization in writing; or (4) as of the following date or event: ______________________________ ***For more information about your privacy rights under HIPAA, please contact the Fund Office.***
V. Authorization to Act on Claims	You have the right to appoint a Personal Representative to act on your behalf to pursue claims for benefits from the Fund. If you wish to do so, please check the box below: ☐ I authorize my Personal Representative to act for me to allow the Fund's staff to discuss my eligibility and claim(s) for benefits. In so doing, I authorize the Fund to release any and all information to the Personal Representative about my claim for benefits under the Fund, including information regarding eligibility, amount of benefits, forms of benefits available to me, any individual rights that I have regarding my protected health information, and my appeal of denial of benefits.

	***Please indicate whether you wish the Fund to send communications regarding your benefit claims to both you and your Personal Representative or only to your Personal Representative*:** ☐ I authorize the Fund to send communications regarding my claim for benefits only to my Personal Representative. ☐ I request that the Fund send communications regarding my claim for benefits to both me and my Personal Representative.
VI. Acknowledgement of Individual Rights	***The Fund reserves the right to deny approval of the appointment of a Personal Representative upon notice to the Participant or Beneficiary signing this form*.** I understand that this authorization is subject to approval by the Fund. I understand that unless otherwise limited by me in this form, information that can be provided by the Fund to the Personal Representative or received by the Fund from the Personal Representative includes all records relating to my health. Information also includes all communications to and from the Fund regarding any claim determination or appeal. I understand that I am under no obligation to sign this form. I acknowledge that I am voluntarily signing this form to release my information to the party I have designated. I understand that eligibility for benefits is not conditioned on this form. I understand that once approved, and unless otherwise indicated on this form, this authorization will remain in effect unless I revoke it. I understand that I have the right to revoke this authorization at any time by submitting a signed statement to that effect to the UFCW Local 1262 and Employers Pension Fund, 1389 Broad Street, Clifton, NJ 07013. I understand that I am entitled to receive a copy of this authorization. I understand that a photocopy or facsimile of this signed authorization form shall be considered as valid as an original signed copy.
VII. Signature	***If the Participant is unable to sign due to incapacity, please submit a copy of a health care power of attorney or court order authorizing the person signing for the Participant.*** ____________________________________ ___________________ Participant's Signature Date ____________________________________ ___________________ Personal Representative's Signature Date
VIII. Acknowledgement By Notary Public	State of ____________________)) ss: County of __________________) On this, the________day of __________, 20____, before me a notary public, the undersigned officer, personally appeared________________, known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged that he executed the same for the purposes therein contained. In witness hereof, I hereunto set my hand and official seal. ____________________________ Notary Public