PERSONAL REPRESENTATIVE REQUEST

The purpose of implementing a Personal Representative is to enable another individual to act on your behalf with respect to:

- Making decisions about your health benefits,
- Requesting and/or disclosing your protected health information, and
- Exercising all of the rights you have under your health benefit plan.

A Personal Representative may either be legally appointed, or designated by a Customer to act on his or her behalf:

- When a Personal representative has been legally appointed, the Personal Representative should complete and sign this form. Supporting legal documentation, such as a power-of-attorney that indicates full health care decision-making authority or guardianship papers, must be submitted with this form.
- When a Personal Representative is being designated by a Customer, the Customer needs to sign this form in the presence of a Notary Public.

Important: All Customer mailings will be directed to the Personal Representative's address.

The Customer retains his or her right to act on his or her own behalf unless the City of Houston Self-Insured Medical Group Health Plans receives legal documentation dictating otherwise.

Note: If your request is granted, it will affect only written and oral communications from City of Houston Self-Insured Medical Group Health Plans. If you also wish your employer, a group health plan, physician or anyone outside City of Houston Self-Insured Medical Group Health Plans to make this change, you must obtain their agreement separately.

VERIFICATION – (Please Print)

Identification of Customer: (The following information is needed for verification. Please complete all applicable items).

Name of Customer: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone No.: _____ Employee ID No.: _____ Group or Account No. on ID Card: _____

Subscriber Name (if different from Customer): _____

Subscriber Relationship to Customer: _____

Identification of Personal Representative:

Name of Personal Representative: (Only one person can be named) _____

Relationship to Customer: _____

Date of Birth of Personal Representative: (answer in the following 8-digit format: 11231949 for November 23, 1949) _____

Address where communications about this Customer should be sent:
_____

What is the reason for this request? _____

VERIFICATION QUESTIONS FOR PERSONAL REPRESENTATIVE

(In this section "You" and "Your" refer to the Personal Representative)

The answers you provide below will be used to verify your identity if you call for protected health information about the Customer. Note that we ask these questions because the answers should be easy for you to remember, but you may enter other numbers as described below.

4 digit PIN (you may use any four digit number): _____

What is your mother's date of birth:(answer in the following 8-digit format:11231949 for November 23, 1949) _____ (You may use any date, however, it cannot be a future date, it must be a legitimate calendar date. For example, we cannot accept 11361949 (November 36, 1949) because there are not 36 days in November. We also cannot accept 11232015 (November 23, 2015) because 2015 is a future date.)

- Please DO NOT provide anyone else with the answers to these questions.
- You should keep a copy of this form

PLEASE NOTE

- *If the information on this form is not complete, the City of Houston Self-Insured Medical Group Health Plans will return the form to you, and this request may not be considered until the City of Houston Self-Insured Medical Group Health Plans receives complete information.*
- *If your Customer ID or date of birth is changed, another form will need to be completed at that time.*
- *If either the Customer or Group changes to a different type of health care benefits coverage provided by the City of Houston Self-Insured Medical Group Health Plans, another form will need to be completed at that time.*
- *Any previous request to send information to an alternate address will be disregarded. All further Customer correspondence will be sent to the address specified above.*
- *You may change or revoke this request by sending a written request to the City of Houston Self-Insured Medical Group Health Plans, at the address on the following page. You can obtain a Change/Revoke form by calling the City of Houston Self-Insured Medical Group Health Plans at the number on your City of Houston Self-Insured Medical Group Health Plans ID card.*

SIGNATURE

Personal Representatives who are appointed by a court order or other legal documentation, **please complete section A.**

Personal Representatives who are designated by a Customer, **please proceed to sections B and C.**

A. Personal Representatives who are legally appointed:

I have read and understand the above information. I acknowledge that by signing this form I have the legal authority to act on behalf of the Customer.

Signature of Personal Representative _____ Date: _____

To safeguard privacy and help make sure no one other than the person whom the Customer designates receives Protected Health Information, this request must be submitted with appropriate supporting legal documentation.

B. Personal Representatives designated by a Customer

To safeguard privacy and help make sure no one other than the person whom the Customer designates receives Protected Health Information, this request must be signed by the Customer and be notarized. (Notary services often can be provided free at a bank where you have an account).

I have read and understand the above information. I acknowledge that by signing this form I authorize the City of Houston Self-Insured Medical Group Health Plans to treat my Personal Representative as myself.

Signature of Customer/Parent/Guardian (This line is for the Customer to sign, authorizing the Personal Representative). _____ Date: _____

If request is made by a Parent/Guardian for a minor child, complete the following:

Customer is a minor _____ years of age. If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

To safeguard your privacy and help make sure no one else is requesting access to your PHI, this request must be notarized. (*Notary services can often be provided free at a bank where you have an account).*

Notary Public Signature

State of)
) SS.
County of

On this the _____ day of _____, 20_____ , before me, _____ (Notary Public), the undersigned officer, personally appeared _____ (member or legal rep. name), known to me (or satisfactorily proven) to be the person whose name is subscribed to the writing instrument and acknowledges that (s)he executed the same for the purposes therein contained.

In witnesses thereof I hereunto set my hand:

_____
Notary Public

My Commission Expires: _____

Please Return This Completed Form To: Privacy Officer, City of Houston Self-Insured Medical Group Health Plans, Human Resources Department, 611 Walker, 4th Floor, Houston, Texas 77002; Email: PrivacyOfficer@houstontx.gov; FAX: 832.393.7208.