INDIANA UNIVERSITY HEALTH PLANS
LONG-TERM DESIGNATION OF PERSONAL REPRESENTATIVE

If you wish for anyone other than yourself to have access to your health information, including your spouse, children, parents, you must use this form. If you do not submit a form to Indiana University Health Plans no one will be able to talk to anyone other than yourself about your claims or eligibility information. PLEASE PRINT ALL INFORMATION AND SIGN YOUR NAME IN SCRIPT.

I,_____(IU Health Plans member), hereby designate the person named below to act as my personal representative with IU Health Plans with full authority to request and obtain verbal and written health information about me. For the purposes of this designation, health information includes, but is not limited to, information about me pertaining to diagnosis, treatment, services planned and received, claims, benefit coverage and enrollment information.

_____

Full Name of Personal Representative (print) Title/Relationship

_____

Mailing Address (city, state, zip)

_____ _____ _____

Daytime Phone Number Evening Phone Number Last 4 digits of Representative's Social Security No. (to verify identity)

_____ _____

Personal Representative Signature Date

_____ _____

IU Health Plans Member Signature Date

_____

Member ID Number

This designation of personal representative is voluntary and may be revoked at any time by writing Indiana University Health Plans, Inc. This is a continuing authorization. This form authorizes the above named representative to act on behalf of the participant for all transactions between the participant and IU Health Plans as long as he/she is an IU Health Plans member.

If you have any questions about Personal Representatives, call IU Health Plans at 1-800-455-9776 or 317-963-9700 or TTY Relay Indiana 1-800-743-3333. Please note that the ORIGINAL completed form must be received by IU Health Plans. Please send this form to:

Indiana University Health Plans
Attn: Enrollment Department
950 N. Meridian St., Suite 400
Indianapolis, IN 46204-1404