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 private 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 Member/Participant 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 Member/Participant, the Member/Participant needs to sign this form in the presence of a Notary Public.

Important: Except for CIGNA Tel-Drug materials, all Member/Participant mailings will be directed to the Personal Representative's address.

CIGNA HealthCare home-delivery pharmacy known as CIGNA Tel-Drug will continue to send the medications, accompanying information and other communications directly to the Member/Participant (not to the Personal Representative) at the address CIGNA Tel-Drug has on file for the Member/Participant. If medications and communications are to be sent to the Personal Representative, please call CIGNA Tel-Drug at 1.800.Tel-Drug.

The Member/Participant retains his or her right to act on his or her own behalf unless CIGNA HealthCare receives legal documentation dictating otherwise.

Note: If your request is granted, it will affect only written and oral communications from CIGNA HealthCare. If you also wish your employer, group health plan, physician or anyone outside of CIGNA HealthCare to make this change, you must obtain their agreement separately.

VERIFICATION – (Please Print)

Identification of Member/Participant:

(The following information is needed for verification.)

Name of Member/Participant: _____ Date of Birth: _____

Phone Number where we can reach you if we need to contact you to process your request (required): _____

Social Security #: _____

Member/Participant ID card number (if applicable): _____

Group or Account # on ID card: _____

Subscriber Name (if different from Member/Participant): _____

Subscriber's Relationship to Member/Participant: _____

Subscriber's Employer Name: _____

Subscriber's Social Security Number (if different from Member/Participant): _____

If you have additional coverage with CIGNA, other than that which is described above, please provide the following information as well:

Other Employer Name: _____

Number on Member/Participant ID card: _____

Group or Account Number on ID card: _____

Does this request apply to all coverage? ☐ Yes ☐ No

Identification of Personal Representative:

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

Relationship to Member/Participant: _____

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

Address where communications about this Member/Participant 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 private health information about the Member/Participant. 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.

Last 4 digits of your favorite credit card (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, and 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 11232010 (November 23, 2010) because 2010 is a future date.

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

PLEASE NOTE

- If the information on this form is not complete, CIGNA HealthCare will return the form to you, and this request will not be considered until CIGNA HealthCare receives complete information.
- If your Member/Participant ID or date of birth is changed, another form will need to be completed at that time.
- If either the Member/Participant or Group changes to a different type of health care benefits coverage provided by CIGNA HealthCare, another form will need to be completed at that time.
- Any previous request to send information to an alternate address will be disregarded. All future Member/Participant correspondence will be sent to the address specified above.
- You may change or revoke this request by sending a written request to CIGNA HealthCare, Central HIPAA Unit, at the address on the following page. You can obtain a Change/Revoke form by calling CIGNA HealthCare Member Services at the number on your CIGNA HealthCare 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 Member/Participant, ***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 Member/Participant.

Signature of Personal Representative _____ **Date:** _____

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

B. Personal Representatives designated by a Member/Participant

To safeguard privacy and help make sure no one other than the person whom the Member/Participant designates receives Private Health Information, this request must be signed by the Member/Participant 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 CIGNA HealthCare to treat my Personal Representative as myself.

Signature of Member/Participant/Parent/Guardian *(This line is for the Member/Participant to sign, authorizing the Personal Representative.)*

_____ **Date:** _____

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

Member/Participant 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.

C. Notary Public Signature

State of)
) ss.
County of)

On this the _____ day of_____, 20____, before me, (Notary Public), the undersigned officer, personally appeared _____ _____ (Member/Participant), known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledges that (s)he executed the same for the purposes therein contained.

In witness whereof I hereunto set my hand.

_____ _____

Notary Public *My Commission Expires*

Please Return This Completed Form To:

CIGNA HEALTHCARE • CENTRAL HIPAA UNIT • PO Box 5400 • Scranton PA 18505