Personal Representative Request

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

- making decisions about your health benefits,
- having your protected health information (PHI) disclosed to them, and
- exercising all the rights you have under your health benefit plans.

A Personal Representative may be either legally appointed or designated by you to act on your behalf (or your dependents' behalf):

- When a Personal Representative has been legally appointed with authority for you or any one of your dependents, you 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 you are designating a Personal Representative for yourself, you must sign this form, along with your Personal Representative, and have it notarized. If you are designating a Personal Representative for one of your dependents who is over the age of 18, you must sign this form, along with your dependent and the Personal Representative, and have all signatures notarized.

VERIFICATION – (Please Print)

Identification of Employee/Insured:

(The following information is needed for verification.)

Employee Name:____ Employee Date of Birth:__________________________

Phone Number (to reach you if needed to process your request):____

Employee Social Security #:______________________________ Employee ID Number:___________________________

Employee Medical ID Card Number:_________________Group or Account # on Medical ID Card:_____________________

Insured's Name (if person other than employee):____

Insured's Relationship to Employee:____

Insured's Employer Name:____

Insured's Social Security #:____

Identification of Personal Representative:

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

Relationship to Employee/Insured: ____

Date of Birth of Personal Representative:____

Address where communications about the Employee/Insured should be sent:

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SIGNATURE

Employees or Insureds with Personal Representatives who are appointed by a Court Order or other legal documentation, ***please complete section A.***

Personal Representatives who are being designated by an Employee, ***please proceed to sections B and C. Please note all signatures in Section B must be notarized in Section C (this can be done by one notary or on separate forms if needed).***

A. I acknowledge that the Personal Representative, listed on page 1, is legally appointed by me to act on my behalf (or my dependents' behalf, if so stated):

I have read and understand the above information. I have attached the applicable legal documentation, and I acknowledge that this information gives authority to the Benefits Division of Maricopa County to discuss information about me (or my dependents if so stated) to the Personal Representative, and I release Maricopa County and its agents from any liability associated with the sharing of such information.

Signature of Employee: ______________________ Date: ______________

Signature of Dependent Insured (over the age of 18): ______________________ Date: ______________

To safeguard privacy and help ensure no one other than the person whom the Employee/Insured designates receives Protected Health Information (PHI), this request must be submitted with appropriate supporting legal documentation.

B. Personal Representative designated by an employee:

To safeguard privacy and help ensure no one other than the person whom the Employee/Insured designates receives Protected Health Information (PHI), this request must be signed by the Employee/Insured and must be notarized.

I have read and understand the above-stated information. I acknowledge that by signing this form I authorize the Maricopa County Employee Benefits Division to treat my Personal Representative as myself.

____

Signature of Employee (*This line is for the employee to sign, authorizing the Personal Representative.*)

____

Date:

I have read and understand the above-stated information. I acknowledge that by signing this form I authorize the Maricopa County Employee Benefits Division to treat my Personal Representative as myself.

____

Signature of Insured (over the age of 18) (*This line is for the dependent/insured to sign, authorizing the Personal Representative.*)

____

Date:

I have read and understand the above-stated information. I acknowledge that by signing this form the Employee/Insured has authorized the Maricopa County Employee Benefits Division to treat me as the Personal Representative of Employee/Insured.

____

Signature of Personal Representative Date:

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

Insured 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 can be processed).

C. Notary Public Signature

State of)
) ss.
County of)

On this the______day of __________________, 20____, before me, (Notary Public), the undersigned officer, personally appeared ________________, [list all individuals who appeared] known to me (or satisfactorily proven) to be the person(s) 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 note that you may change or revoke this request by sending a written request to the address below:

Please return this completed form to:
Maricopa County Employee Benefits Division, 301 W. Jefferson St., Suite 3200, Phoenix, AZ 85003