ABS Automated Benefit Services

Request for Appointment of Personal Representative

Read instructions on p. 3 before completing this form. ALL FIELDS MUST BE COMPLETED.

A separate form is required for each member on the policy or coverage, as needed. Please print legibly, or type, except where signature is needed.

To request a personal representative, please complete the information below, sign in the space provided and return to: Automated Benefit Services ("ABS"), 800 Tower Drive, Troy MI, 48098, or FAX: (586) 693-4321

SECTION A: MEMBER INFORMATION *(check whether request is for participant or dependent)*

Name *(☐Participant ☐Dependent):* _____

Participant Identification #: _____

Date of Birth: ____/____/____ (MM/DD/YYYY) Telephone # _____

Address: _____

City: _____ State: _____ ZIP: _____

I, _____ *(member)*, hereby appoint _____ *(personal representative)* to be designated as my personal representative. I understand this request applies to communications from ABS and its business associates about my private information. I also understand that mental health and/or substance abuse private information may be disclosed if I have utilized such services.

Time Period for Representation: From: ____/____/____ (MM/DD/YYYY) To: ____/____/____ (MM/DD/YYYY)

NOTE: If no time period is provided, this request will remain in effect until the member or his/her legal representative notifies ABS in writing requesting a change.

SECTION B: PURPOSE OF REPRESENTATION: *(select one)*

☐**Account Inquiries Only (Limited Authority):** This means that ABS is allowed to disclose private information to the individual selected. This individual would have access to information (select all that apply):

☐claims ☐enrollment ☐premiums ☐appeals

☐**Mental Health/Substance Abuse Consent:** Check this box if, in addition to the "Limited Authority" above, you also want your designated personal representative to have access to your mental health & substance abuse information.

☐**Act on behalf of Member & Account Inquiries (Full Authority):** Not only can ABS disclose private information to the individual selected, but this individual will be able to act on behalf of the member in all transactions such as claims, enrollment, appeals, etcetera. For that reason, this option should ONLY be chosen if the member is sure he/she no longer wants to release all account privileges and rights (generally, only in circumstances of incapacity or incompetence (adults), or in the representation of a child; typically, not for spouse- to-spouse representation). If the subscriber or personal representative wants information sent to another address, please call customer service using the number on the identification card.

☐**Mental Health/Substance Abuse Consent:** Check this box if, in addition to the "Account Inquiries Only" above, you also want your designated personal representative to have access to your mental health & substance abuse information.

☐**Appeal Authority Only:** This means that ABS will only allow the personal representative to act on behalf of the member in the case of a specific appeal.
Please provide information regarding the appeal:

Claim Number: _____ Date of Service: : _____ Provider: : _____

Any additional information that may assist with identifying what you are appealing. _____

_____

_____

SECTION C: PERSONAL REPRESENTATIVE INFORMATION: *(required for privacy verification purposes)*

Name (Last, First, MI): _____

Last 4 Digits of Social Security #: _____ Date of Birth: ____ / ____ / ____
MM DD YYYY

Address: _____

City: _____ State: _____ ZIP: _____

Telephone #: _____ Relationship to the member: _____

NOTE: If the representative is court-ordered or has another legal designation (examples: power of attorney, living will, executor or administrator of probate estate), you must attach/include copy of the official document(s) if not already provided. If you are a documented legal representative, you may make this Request and sign this form below on behalf of the member.

☐ Check here if you want your response to this request sent via email. Email address: _____

Signature of ☐ Member ☐ Requestor: _____ Date: ____ / ____ / ____
(check whether member or other requestor) MM DD YYYY

Printed Name: _____

INSTRUCTIONS

REQUEST FOR APPOINTMENT OF PERSONAL REPRESENTATIVE

(NOTE: This form is not to be used for a member's change of address. For member change of address, please contact Customer Service or Enrollment)

General Instructions: All fields are required to be completed unless otherwise specified.

This form must be completed when a member wishes to appoint an individual as its HIPAA personal representative regarding communications with ABS or wishes to extend the authority of an already existing personal representative. This form is not intended to be used for appointing spouses or parents on the coverage as personal representatives. Spouses and parents on the coverage are automatically treated as personal representatives with limited authority of the other spouse and other dependents on the coverage. However, completion of this form is required when the proposed (spouse or parent) personal representative would like to become the member's personal representative with full authority.

All required legal documents will undergo a validation process by ABS. A separate request form and documentation is required for each member on the coverage, as applicable, even if authorizing the same personal representative.

Section A: Member Information

This section requests information related to the member for which a personal representative is being requested. Since this information is used for both identification and verification purposes, the information included in this section should match the most current information for the member/subscriber in ABS's systems. Please, be aware that this form may be denied if the information on the form does not match the information in our systems.

Section B: Purpose of Representation

Members can assign one of two available levels of authority to their personal representative: limited authority and full authority. For each level of authority, additional options are also available.

Limited Authority (Account Inquiries Only): If you select this option, your personal representative is allowed to make inquiries about your account and ABS is allowed to disclose your private information to that individual, such as claims, enrollment, premiums and appeals whichever is elected. Your personal representative will not be allowed to make changes to your policy. ABS will disclose mental health or substance abuse information under this option only if the member makes this selection on the form.

Full Authority (Act on behalf of Member & Account Inquiries): If you select this option, your personal representative will have all the authority that you currently have over the account. That is, not only will your personal representative be allowed to make inquiries about your private information, he/she will also be allowed to make and request changes and updates to your account, including the termination of your policy.

ABS will not disclose mental health or substance abuse information to the personal representatives, unless the member or its legal representative selects that option on the form.

Appeal Authority Only: This means that ABS will only allow the personal representative to act on behalf of the member in the case of a specific appeal. All requested information must be completed.

Section C: Personal Representative Information

The requested information will be used by ABS for identification and verification purposes. The personal representative will be required to disclose this information during a phone call if he/she wishes to receive private information about the member.

1. *Time Period of Representation:* If no termination date is entered, the request will remain in effect until the member/legal representative notifies the change to ABS in writing. Format: (MM/DD/YYYY). **Note:** The appointment will be effective on the date that ABS processes and approves the form.

Mail this form to:

Automated Benefit Services
Attn: Customer Service
800 Tower Drive
Troy, MI 48098

Or Fax to: (586) 693-4321

ACA Section 1557 Notice of Non-Discrimination

The Medical Plan ("Plan") complies with Federal civil rights laws, and does not discriminate on the basis of race, color, national origin, age, disability or sex. The Medical Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Medical Plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters; and
- Written information in other formats (large print, audio, accessible electronic formats and other formats).

The Medical Plan provides free language services to people whose primary language is not English, such as:

- Qualified interpreters; and
- Information written in other languages.

If you need these services, contact the Vice President Corporate Responsibility at section1557@abs-tpa.com

If you believe that the Medical Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by contacting our customer service department at (800) 225-9369 between the hours of 8:30AM – 4:30PM eastern standard time.

You can file a grievance by mail or email. If you need help filing a grievance the Vice President Corporate Responsibility is available to help you at section1557@abs-tpa.com
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *http://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

(800) 368-1090 or (800) 537-7697 (TDD)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. section1557@abs-tpa.com

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. section1557@abs-tpa.com

注意：如果您使用繁體中文，您可以免費獲得語言援助服務 section1557@abs-tpa.com

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. section1557@abs-tpa.com

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. section1557@abs-tpa.com

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. section1557@abs-tpa.com

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم section1557@abs-tpa.com

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. section1557@abs-tpa.com

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. section1557@abs-tpa.com

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. section1557@abs-tpa.com

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. section1557@abs-tpa.com

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. section1557@abs-tpa.com

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।section1557@abs-tpa.com

శ్రద్ధ పెట్టండి: ఒకవేళ మీరు తెలుగు భాష మాట్లాడుతున్నట్లయితే, మీ కొరకు తెలుగు భాషా సహాయక సేవలు ఉచితంగా లభిస్తాయి
section1557@abs-tpa.com

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال

section1557@abs-tpa.com