

**Local 705 International Brotherhood of Teamsters
Health and Welfare Fund**

**Appointment of Family Personal Representatives to
Receive Protected Health Information**

I, _____ [Name of Participant], and my Spouse,
_____ [Name of Spouse], residing at
_____ [mailing address]
at (_____) _____ [phone number], hereby designate each other to act on each other's
behalf and on behalf of our adult children who have signed this appointment, as described below.

We, _____
[Insert Names of Adult Children], who have signed this Appointment below, hereby designate our parents
to act on our behalf, as described below.

We, the Participant and Spouse and our adult children who have signed this Appointment below,
authorize our Personal Representative to act for us to:

- Receive any Protected Health Information or information that is (or would be) provided to us as a participant or beneficiary of the Plan, including but not limited to, any information that relates to our claims for coverage or benefits under the Plan, and
- Enforce any individual rights that we have regarding our Protected Health Information under HIPAA.

We understand that this designation is subject to approval by the Fund. We also understand that, once approved, this designation will remain in effect unless we revoke it. We understand that we have the right to revoke this designation at any time by submitting a signed statement to that effect to the Fund Office.

We certify that we have reviewed the Plan's Policy for Recognition of Personal Representative.

Participant's Signature

Date

Social Security Number

Date

Spouse's Signature

Date

Adult Child's Signature

Date

Adult Child's Signature

Date

Adult Child's Signature

Date