

Appointment of Authorized Representative
Under the Group Health Plan's Claims and Appeals Procedures

I, _____ [name of group health plan participant] hereby appoint _____ to act on my behalf [name of Authorized Representative] ("Representative") or on behalf of _____ [name of patient if minor and dependent of group health plan participant] in connection with the claim(s) for coverage or benefits or appeal of an adverse benefit determination from _____ [name of medical service provider] ("Provider") for dates _____ [date(s) of service] under my employer's group health plan ("Plan"). I authorize my Representative to receive any and all information requested by such Representative pursuant to the Plan's claims procedures with regard to the services rendered by Provider for such dates indicated above, and to act for me and for my dependent, if named above as the patient, in providing any information to the Plan that relates to any claim for coverage or benefits under the Plan or for the appeal of an adverse benefits determination under the Plan.

This Appointment of Authorization Representative supersedes any existing authorization by me or on behalf of myself or my dependent named above. Any other authorization will be deemed null and void. This Appointment of Authorized Representative will not be effective until fully executed and dated below. Assignment of benefits is prohibited under the Plan.

IMPORTANT: All information and notifications relevant to the services rendered by Provider, and provided under the Plan's claims procedures, on the above indicated dates from the Plan will be directed to the Authorized Representative appointed through this form and not to you. If you would also like a copy of the appeal determination letter, please reach out to Collective Health at 844-803-0214 for further assistance.

Claimant Signature Date

Authorized Representative Signature Date