WTA Benefit Trust
APPOINTMENT OF PERSONAL REPRESENTATIVE

Name and address of individual covered by benefit trust: _____

_____ Phone: ( ) _____

I hereby designate the following person as my personal representative (name and address):

_____

_____ Phone: ( ) _____

Relationship to individual: _____

I hereby authorize the above named personal representative to act for me in receiving any protected health information ("PHI") that may be provided to me as a participant or beneficiary of the Plan.

OR

I hereby authorize my personal representative to act for me in receiving the following PHI to conduct the following functions on my behalf:

_____

_____

I understand that this appointment is subject to the Plan's approval. If approved, this appointment will remain in effect unless revoked. I understand that I have the right to revoke this appointment at any time by submitting to the Plan, in writing, a statement indicating that intent.

Signature: _____ Date: _____
Individual

Signature: _____ Date: _____
Personal Representative

I certify that I have received the privacy notice given by WTA Benefit Trust regarding the privacy of protected health information (PHI) as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Privacy Notice: newsHIPAAnotice.html or request a hard copy)

Signature: _____ Date: _____
Individual

Signature: _____ Date: _____
Personal Representative