WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

DESIGNATION OF AUTHORIZED REPRESENTATIVE

In order to recognize someone other than the claimant as an authorized representative, Wisconsin Laborers' Health Fund (hereinafter referred to as the PLAN) must receive a valid Designation of Authorized Representative form that has been completed by the claimant. The PLAN does not condition eligibility, enrollment, or payment of benefits upon receipt of the authorization.

_____ _____
Claimant Name (print) Social Security Number

I hereby authorize the PLAN and all Business Associates acting on its behalf to recognize the person name herein as my representative for the purposes described below, and to disclose relevant health information to:

_____
Name of person representing you (print)

_____
Street address

_____
City, State, Zip code

_____
Area Code & Telephone Number

☐ All Medical Claims
☐ All Dental Claims
☐ All Vision Claims
☐ All Time Loss (disability) Claims
☐ Death Benefit Claims
☐ Flexible Spending Account (FSA) Claims
☐ Pension: ☐ Application ☐ Benefit Payments

☐ Specific Medical, Dental or Vision claim:
Provider: _____
Date of Service: _____
☐ Specific Time Loss (disability) claim:
Dates: _____

☐ Other (please be as specific as possible): _____

_____

_____

☐ I request that copies of all relevant communications (explanations of benefits, letters, etc.) be sent to my authorized representative while this designation is in effect.

I understand that this Authorization does not ensure that the person I am authorizing to receive health information about me will treat such information as confidential. ***I understand that I may revoke this Authorization at any time by submitting a Cancellation of Authorized Representative form to the PLAN***. This Authorization is valid for one year following the date on which it is signed below unless a different expiration date or event is indicated here, _____, or upon receipt by the PLAN of a Cancellation of Authorization form.

_____ _____
Claimant's Signature Date

A copy of this authorization form will be sent to your designated representative at the address listed above.