MEBA MEDICAL AND BENEFITS PLAN

DESIGNATION OF AUTHORIZED REPRESENTATIVE FOR CLAIMS AND APPEALS

Pursuant to the claims and appeals procedures for benefits described in the MEBA Medical and Benefits Plan ("Plan"), you may name a representative to act on your behalf with respect to any aspect of your claim or appeal. If you would like to designate a representative, please complete this form and return it to the Plan Office.

In order for the Plan to be able to disclose health information that is relevant to your claim and/or appeal to the representative designated below, in accordance with the privacy regulations issued under the Health Information Portability and Accountability Act of 1996 ("HIPAA"), please also complete the attached form, entitled "Designation of Health Information Recipient." **If you do not sign and return the Designation of Health Information Recipient, the Plan cannot release information, records or documents containing protected health information to your designated representative.**

1. Please provide the following information:

Your Name: ____

Address: ____
____
____

Social Security Number ____

Telephone: ____________________________

Email or Facsimile: ____________________________ (please note if none available)

If you are not the covered employee (Plan Participant), please provide the following information for the Participant:

Participant's Name: ____

Address: ____
____
____

Social Security Number ____

Telephone: ____________________________

Email or Facsimile: ____________________________ (please note if none available)

Relationship to the Participant: ______________________________________

2. I hereby designate the following person to act as my representative for all purposes related to the Plan's claims and appeals process, including requesting documents.

Representative's Name:____

Address: ____
____
____

Telephone: ___________________________

Email or Facsimile: ___________________________ (please note if none available)

Relationship: ___________________________

3. I authorize my representative (named above) to act on my behalf in connection with: [*choose one*]

claim # ____________

or

a claim for services rendered to me on _________ [*insert date*] by ___________________ [*insert name of provider*]

or

a claim for services rendered to my dependent, _____________________ *[insert name]*, ________________________ *[insert relationship]*, ____________________ *[insert Social Security Number]* on ___________ [*insert date*] by __________________ [*insert name of provider*].

4. I request that the Plan send all requested information, notices and decisions relating to any aspect of my claim and/or appeal to my representative instead of to me.

5. I understand that this designation will remain in effect until the conclusion of the Plan's claims and appeals process, for as long as a valid Designation of Health Information Recipient is in effect. I also understand that I have the right to revoke my designation of a representative at any time by sending a letter to that effect to:

MEBA Medical and Benefits Plan
1007 Eastern Avenue
Baltimore, MD 21202-4345

____
Signature

____
Date

Please return this form and the attached Designation of Health Information Recipient to:

MEBA Medical and Benefits Plan
1007 Eastern Avenue
Baltimore, MD 21202-4345

20635854v2