Trustmark Insurance Company/Trustmark Life Insurance Company
(Referred to as Trustmark)

APPOINTMENT OF PERSONAL REPRESENTATIVE

I. MEMBER DATA

Personal Representative is requested for: (*List only one individual per form)*

_____

Relationship to Member: ____ Self ____ Dependent

Member's Name: _____
Member's ID Number: _____
Group/Policy Number: _____
Member's Address: _____
Member's City/State/Zip:_____
Member's Telephone No.: _____

II. NATURE OF REQUEST FOR PERSONAL REPRESENTATIVE

An individual has a right to appoint a Personal Representative to act on their behalf for the purpose of making decisions regarding their enrollment/disenrollment, coverage and benefits as well as request, access or receive Personal Health Information (PHI)/ Personally Identifiable Health Information (PII) about them or they may designate an individual to discuss information related to claims but not to make decisions or changes regarding the member or dependents.

A. I **appoint** _____ as my Personal Representative to make decisions or changes about my enrollment/disenrollment, coverage and benefits, or to request, access or receive PHI/PII about myself and/or _____.

B. I **authorize** _____ to act as my Authorized Personal Representative to only discuss information related to coverage, benefits, eligibility, claims, etc. about myself and/or _____.

C. I **authorize** _____ to discuss, on my behalf, my PHI/PII only for the condition or claim listed below:
_____
_____

D. I ☐ **consent/** ☐ **do not consent** to disclose information that may contain sensitive information regarding:

- ☐ Physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment, and
- ☐ HIV testing and/or AIDS diagnosis or treatment

III. MEMBER'S RIGHTS

I understand that this appointment/authorization shall be effective from the date this form is signed. This appointment/authorization shall remain valid **(REQUIRED - CHECK ONE)**

- o Until revoked in writing
- o Until _____,20___

I understand that this appointment/authorization to release information to my Personal Representative/Authorized Representative will automatically expire two years following the termination of my health plan enrollment.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand my refusal to sign an Appointment of Personal Representative form will not prevent treatment, payment, or enrollment in a health plan or eligibility for benefits

I am entitled to a copy of this form

All individuals 18 and older or otherwise emancipated by a court of law are required to complete and sign their own personal representative form. Trustmark cannot grant the request for an appointment/authorization without their written request.

IV. PERSONAL REPRESENTATIVE INFORMATION

Name of Personal Representative (please print): _____
Relationship to Insured: _____
Address: _____
City/State/Zip: _____
Telephone Number: _____

If this form is signed by someone other than the member or parent, such as a legal representative or guarding on behalf of the member, please submits a copy of applicable power of attorney or court order that shows the authority of the legal representative to act on the member's behalf.

Member/Designated Legal Representative/Guardian Signature Printed Name:
_____

Member/Designated Legal Representative/Guardian Signature: _____

Date: _____

Mail Completed Form To:
Privacy Officer
Privacy Office
Trustmark
PO Box 7961Lake Forest, IL 60045-7961