



Yes     No    4. I instruct UCare to send all member correspondence to my representative at his/her mailing address, shown below. I want my representative to receive confidential information about me, such as claims information. I understand that if I check the "Yes" box, my representative will receive ALL member materials, updates, premium notices, claims information, and other mail on my behalf. I understand that I will NOT receive extra copies from UCare. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services and treatment for alcohol or drug abuse.

Yes     No    4. I allow my representative to make decisions, in my best interest, regarding disenrollment from UCare.

Yes     No    5. Other (please explain): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Relationship to Representative.** My representative is my \_\_\_\_\_  
(spouse, parent, child, friend, etc.)

**I understand that by signing below I am giving another person the legal power to make certain decisions for me on my behalf. I also understand that UCare will rely on this authorization to release private information to my representative and make changes to my member status. I understand that I may revoke these authorizations at any time by telling UCare in writing that I wish to do so. However, I understand that my revocation of this authorization will not affect any action UCare has taken, or any information that UCare has already released, based upon this authorization before UCare actually received my request to revoke it.**

I understand that UCare does not condition treatment, payment, enrollment or eligibility for benefits on the execution of this form.

To become effective, this document must be completed and signed by me, accepted by my representative, and either notarized (*Option 1*) or witnessed by two witnesses (*Option 2*).

Signature: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
Medicare #: \_\_\_\_\_

HICN #: \_\_\_\_\_

If I cannot physically sign my name, I can ask someone to sign for me.

Printed name of person I ask to sign for me: \_\_\_\_\_

Signature of person I ask to sign for me: \_\_\_\_\_

**ACCEPTANCE BY REPRESENTATIVE:** *(to be completed by the representative)*

The undersigned, who has been designated as a representative in this document, accepts appointment as the named representative, subject to the terms and conditions of this document. The undersigned certifies that he or she has not been disqualified from acting as the member's representative and waives any right to any fee for representation if a provider or supplier for the member.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone #: \_\_\_\_\_

**Waiver of Fee for Representation:** Instructions: A provider or suppliers who provided services that are the subject of an appeal may not charge a fee for such representation. This section must be filled out if the appointed representative is a provider or supplier who furnished the services that are the subject matter of the appeal. By signing below, you agree to waive any fee for representation.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

*Expiration: This form is valid for one year from the date of signature.*

*Please have either Option 1 or Option 2 completed as shown.*

**Option 1: To be completed by a Notary Public**

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_  
by \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

**Option 2: To be completed by 2 witnesses**

By signing below, each witness certifies that he or she is at least 19 years of age, is not an employee of UCare, and is not the named representative. Each witnesses; signature below acknowledges that the above-named person acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.

\_\_\_\_\_  
Signature of Witness

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Witness

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

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U2231 (10/09)