

STATEMENT OF REPRESENTATIVE *UCare for Seniors (HMO-POS)*

I _____, appoint _____
(member's name) *(representative's name)*

to act as my representative for certain purposes relating to my enrollment and membership in UCare, as described below. This person will be my agent, and I authorize him/her to act for me and in my name to the extent stated in this document in the same way that I could act if I were personally present. I grant my representative the power and authority to do the things below by checking "Yes". Checking "No" means that my representative is not authorized to make those decisions. My representative will have the power marked "Yes" below beginning on the day that I sign this document. He/she will continue to have these powers if I become incompetent or incapacitated or otherwise unable to make these decisions on my own.

I understand that if my representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my confidential information received by my representative, as designated below, may no longer be protected by privacy laws and may be further disclosed by my representative without my authorization.

Yes No 1. I allow my representative to enroll me in an appropriate UCare plan, including *UCare for Seniors*, or Medicare supplement insurance; to purchase other appropriate hospital/medical insurance and custodial care insurance; to pay all insurance premiums; to select from the benefit options under such policies; and to pursue all insurance claims on my behalf.

Yes No 2. I allow my representative to make decisions regarding my membership in UCare, including changing my primary care clinic, discussing claims and insurance related issues with UCare representatives, and receiving from or discussing with UCare representatives confidential health information about me and my health status. 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 3. 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): _____

Note: Due to regulatory requirements, this Statement of Representative form may not be used to allow your representative to file a grievance, appeal or request a coverage determination on your behalf. The Centers for Medicare and Medicaid Services (CMS) requires a completed CMS-1696 form, or the equivalent, in order to designate a representative to file a grievance, appeal or coverage determination on your behalf.

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 #: _____

UCare Member #: _____

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.

Printed Name: _____

Signature: _____

Address: _____

Phone #: _____

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

Signature of Witness

Printed Name: _____

Printed Name: _____

Address: _____

Address: _____

UCare Minnesota and UCare Wisconsin, Inc. are health plans with Medicare contracts.

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