APPOINTMENT OF PERSONAL REPRESENTATIVE FOR HEALTH PAYMENT PURPOSES

I voluntarily appoint the individual or individuals named below as my authorized representative to act for me in all payment matters (as defined by HIPAA), including, but not limited to questions regarding enrollment, claims status, utilization review, pre-existing conditions, coordination of benefits, and subrogation, except as specifically provided below.

This appointment becomes effective on the date signed, and will remain in effect until I notify either my employer or Nyhart that this appointment is terminated. Notice of termination may be written or verbal.

____
My Name (Printed)

____
Signature

____
Employee's Social Security Number

____
Name of Employer

____
Group Number

____
Date

List Any Matters in Which Representative May Not Act:

____

____
Signature of Witness*

____
Signature of Witness*

____
Name of My Representative (Printed)

____
Relationship to Me

____
Representative's Date of Birth

____

____

____
Representative's Address

____
Name of Additional Representative (Optional)

____
Relationship to Me

____
Representative's Date of Birth

____

____

____
Representative's Address

*Witnesses must be at least 18 years old. They may not be your blood relative, or a person you have named as your representative.

Return to:
Nyhart
Attn: Customer Service
P. O. Box 80884
Indianapolis, IN 46280-0884
Or fax to Nyhart at 317-803-7890