FAMILY PERSONAL REPRESENTATIVE FORM

I, ____ (Name of Participant), and my Spouse,

____, (Name of Spouse), residing at

____ (mailing address) at

_________________________ (phone number), hereby designate each other to act on each other's behalf and on behalf of our adult children who have signed this appointment as described below.

We, ____ (Insert Names of Adult Children), who have signed this Appointment below, hereby designate our parents to act on our behalf as described below.

We, the Participant and Spouse and our adult child/children who have signed this Appointment below, authorize our Personal Representatives to act for us to:

- Receive any Protected Health Information or information that is (or would be) provided to us as a participant or beneficiary of the Plan, including but not limited to any information that relates to our claims for coverage or benefits under the Plan, and
- Enforce any individual rights that we have regarding our Protected Health Information under HIPAA.

We understand that this designation is subject to approval by the Plan. We also understand that, once approved, this designation will remain in effect unless we revoke it. We understand that we have the right to revoke this designation at any time by submitting a signed statement to that effect to the Fund Office. A Divorce will automatically revoke the right of "spouses" and "participants" authority with respect to each other if the Fund is notified in writing along with the divorce decree.

We certify that we have reviewed the Plan's Policy for Recognition of Personal Representative.

____________________________________	____________________________________
Participant's Signature	Date
____________________________________	____________________________________
Spouse's Signature	Date
____________________________________	____________________________________
Adult Child's Signature	Date
____________________________________	____________________________________
Adult Child's Signature	Date