North Atlantic States Carpenters
Health Benefits Fund

Massachusetts Office
350 Fordham Road
Wilmington, MA 01887
www.carpentersfund.org
Phone: 800-344-1515
Fax: 978-752-1148

Connecticut Office
10 Broadway
Hamden, CT 06518
www.carpentersfund.org
Phone: 800-922-6026
Fax: 203-288-3235

Personal Representative Form

I _____(Please Print Name) hereby designate the person I have identified below as my **Personal Representative**.

By signing this form, I authorize the North Atlantic States Carpenters Health Benefits Fund to disclose my health information (information that constitutes **Protected Health Information (PHI**) as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996). I understand that I am under no obligation to sign this form. I have signed this form voluntarily to document my wishes regarding the disclosure of the Protected Health Information to my Personal Representative. I understand that my Personal Representative will have access to all my Protected Health Information, and that this access may be both Oral and Written. I understand that all written responses mailed by the Health Fund will be sent to my personal address of record.

Name of Personal Representative: _____

Address of Personal Representative: _____

_____

Date of Birth of Personal Representative: _____

Identity Verification of Personal Representative: *For security purposes, please specify a personal question we will ask your Personal Representative to answer when calling into our office for your information.* ***We will not be able to speak to your Personal Representative unless we have this security question and answer section completed.***

Question:_____

Please Print Legibly (Question only YOUR Personal Representative knows the answer to; relative to him/her.) Examples: What is my favorite Pet's name? ; What is my mother's maiden name? ; What hospital was I born at? ; What elementary school did I attend? ; ETC.

Answer: _____

Please Print Legibly

I understand that this permission will not terminate until such time that I make the request to terminate the access of my Personal Representative in writing and mail it to one of the addresses listed above:

North Atlantic States Carpenters Health Benefits Fund
ATTN: Privacy Officer

Participant Name: _____

Address: _____

_____

Participant Health Fund Identification Number: _____

Signature: _____

Date: _____

Important Notice:
This form must be completed IN FULL before the Health Fund may execute it.