Blue Cross Blue Shield of Rhode Island

Member's Designation of a Personal Representative

Please note: The member named below must sign this designation and consent to the use and disclosure of their information by the Personal Representative for healthcare coverage issues.

Member's Name: _____DOB: _____ Member's ID#: _____

Address: _____ Daytime Phone Number: _____

I designate the following individual to act as my Personal Representative:

Name: _____ Relationship: _____

Address: _____ Daytime Phone Number: _____

Scope of Designation: The individual named as my Personal Representative may act on my behalf in regard to my healthcare coverage through Blue Cross & Blue Shield of Rhode Island (BCBSRI) and may perform the activities selected below. This applies to any and all claims, medical records, and information relating to me (including, but not limited to, records related to alcoholism, substance abuse, mental health, prescriptions, and HIV status or test results).

This designation will not be effective unless one or more of the boxes below are checked.

- ☐ BCBSRI may respond to questions from my Personal Representative about my healthcare coverage to the same extent that BCBSRI would disclose this information to me.
- ☐ BCBSRI may make changes to my healthcare coverage as requested by my Personal Representative. These include address changes, electing my primary care provider (PCP), or requesting an identification card.
- ☐ BCBSRI may accept an appeal from my Personal Representative on my behalf involving any and all claims (does not apply to BlueCHiP for Medicare members).

This Designation shall remain valid for the length of time checked below:

___ remains in effect for no more than twenty-four (24) months from the date this designation was signed, or until I revoke it, whichever comes first

___ remains in effect for a specific time period, from: _____ to: _____ (less than twenty-four (24) months from the date of signature)

I understand that I may revoke this designation at any time by notifying the BCBSRI Customer Service Department, in writing, at 444 Westminster Street, Providence, RI 02903. I understand that a revocation will not apply to information that was already released while this designation was in effect. Once information has been released according to these instructions, BCBSRI will not be able to limit the recipient's use or disclosure of the information, and privacy laws may no longer protect the information.

I agree that a photocopy of this designation is as valid as the original.

Member's Signature: _____Member's Name: _____ Date:_____