FARM BUREAU HEALTH PLANS
PERSONAL REPRESENTATIVE DESIGNATION INSTRUCTIONS

The following form is used to designate someone as a personal representative. Appointing a representative is completely optional and allows the designated person to contact us and receive detailed information regarding the member's Farm Bureau Health Plans coverage and claims information including protected health information. Only one member may be listed per form.

For a minor child, (17 years or younger) you must be the subscriber of the health plan to sign this form on their behalf. A child 18 years or older will need to fill out and sign this form themselves.

List information for the member whose health information will be shared.

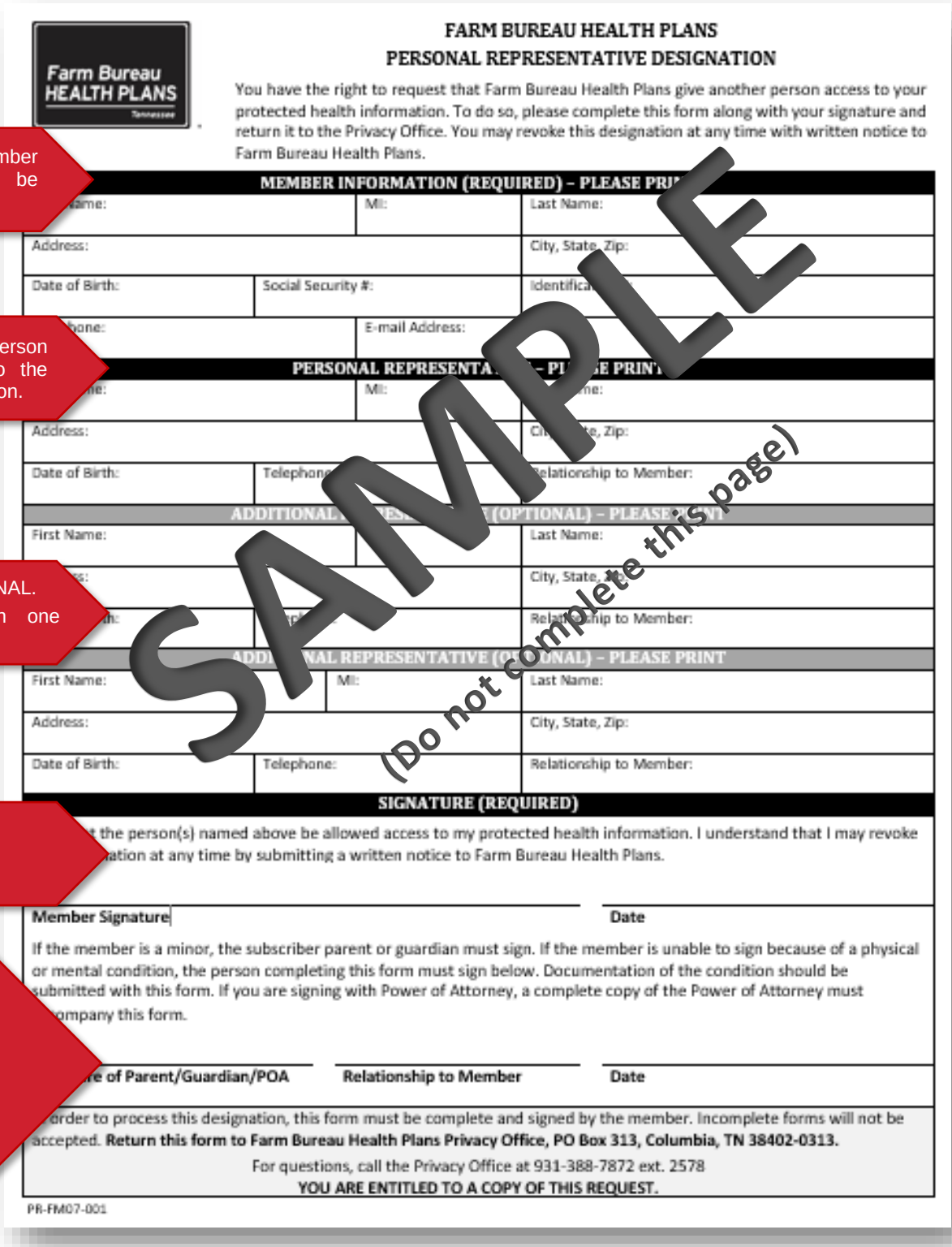
List information for the person designated to have access to the above member's health information.

THESE SECTIONS ARE OPTIONAL.
Complete only if more than one representative is needed.

Sign here if you are the ADULT MEMBER listed above

Sign here if you are:
PARENT/GUARDIAN
- Child must be a minor (under 17)
- Parent must be subscriber on application

POWER OF ATTORNEY/ CONSERVATOR
- Papers are required if not already on file



FARM BUREAU HEALTH PLANS
PERSONAL REPRESENTATIVE DESIGNATION

You have the right to request that Farm Bureau Health Plans give another person access to your protected health information. To do so, please complete this form along with your signature and return it to the Privacy Office. You may revoke this designation at any time with written notice to Farm Bureau Health Plans.

MEMBER INFORMATION (REQUIRED) – PLEASE PRI

ame: | MI: | Last Name:
Address: | City, State, Zip:
Date of Birth: | Social Security #: | Identifica
hone: | E-mail Address:

PERSONAL REPRESENTA – PL E PRINT

e: | MI: | e:
Address: | e, Zip:
Date of Birth: | Telephon | elationship to Member:

ADDITIONAL ES (OPTIONAL) – PLEASE PRINT

First Name: | Last Name:
s: | City, State,
h: | Relationship to Member:

ADDI NAL REPRESENTATIVE (OPTIONAL) – PLEASE PRINT

First Name: | MI: | Last Name:
Address: | City, State, Zip:
Date of Birth: | Telephone: | Relationship to Member:

SIGNATURE (REQUIRED)

t the person(s) named above be allowed access to my protected health information. I understand that I may revoke ation at any time by submitting a written notice to Farm Bureau Health Plans.

Member Signature | Date

If the member is a minor, the subscriber parent or guardian must sign. If the member is unable to sign because of a physical or mental condition, the person completing this form must sign below. Documentation of the condition should be submitted with this form. If you are signing with Power of Attorney, a complete copy of the Power of Attorney must ompany this form.

re of Parent/Guardian/POA | Relationship to Member | Date

order to process this designation, this form must be complete and signed by the member. Incomplete forms will not be ccepted. **Return this form to Farm Bureau Health Plans Privacy Office, PO Box 313, Columbia, TN 38402-0313.**

For questions, call the Privacy Office at 931-388-7872 ext. 2578
YOU ARE ENTITLED TO A COPY OF THIS REQUEST.

PR-FM07-001

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MEMBER INFORMATION (REQUIRED) – PLEASE PRINT			
First Name:		MI:	Last Name:
Address:			City, State, Zip:
Date of Birth:	Social Security #:		Identification #:
Telephone:		E-mail Address:	

PERSONAL REPRESENTATIVE – PLEASE PRINT			
First Name:		MI:	Last Name:
Address:			City, State, Zip:
Date of Birth:	Telephone:		Relationship to Member:

ADDITIONAL REPRESENTATIVE (OPTIONAL) – PLEASE PRINT			
First Name:		MI:	Last Name:
Address:			City, State, Zip:
Date of Birth:	Telephone:		Relationship to Member:

ADDITIONAL REPRESENTATIVE (OPTIONAL) – PLEASE PRINT			
First Name:		MI:	Last Name:
Address:			City, State, Zip:
Date of Birth:	Telephone:		Relationship to Member:

SIGNATURE (REQUIRED)

I request the person(s) named above be allowed access to my protected health information. I understand that I may revoke this designation at any time by submitting a written notice to Farm Bureau Health Plans.

Member Signature **Date**

If the member is a minor, the subscriber parent or guardian must sign. If the member is unable to sign because of a physical or mental condition, the person completing this form must sign below. Documentation of the condition should be submitted with this form. If you are signing with Power of Attorney, a complete copy of the Power of Attorney must accompany this form.

Signature of Parent/Guardian/POA **Relationship to Member** **Date**

In order to process this designation, this form must be complete and signed by the member. Incomplete forms will not be accepted. **Return this form to Farm Bureau Health Plans Privacy Office, PO Box 313, Columbia, TN 38402-0313.**

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