

# BENE-FLEX HAWAII, INC.

*Cafeteria Plan Administrator*

## **AUTHORIZATION TO APPOINT A PERSONAL REPRESENTATIVE FORM**

To appoint a personal representative please complete this form. Bene-Flex Hawaii, Inc. and/or its affiliates will provide the same rights to your confidential account information to your appointed personal representative as are provided to you.

### Employee Participant Information

First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer: \_\_\_\_\_

### Your Rights As Provided by Federal Law

You have the right to authorize another person to use and receive the confidential account information used by Bene-Flex Hawaii, Inc. The person you identify below may not be subject to federal health information privacy laws. If this is the case, the authorized person(s) may further release your confidential account information and the federal health information laws may no longer protect it. You have the right to request a copy of this signed form at any time.

**This authorization is voluntary.** We will not condition your enrollment in the cafeteria plan or eligibility on receiving this authorization. You may revoke this authorization at any time by giving written notice to Bene-Flex Hawaii, Inc. at least 14 days prior to the effective date.

### Authorization to Appoint a Personal Representative

1. Please state the purpose of this authorization:

\_\_\_\_\_ Appoint a personal representative to act on my behalf.

\_\_\_\_\_ Other: For the following purpose only. (Please describe in detail): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. I hereby authorize the request and release of my confidential account information held by Bene-Flex Hawaii, Inc. to my personal representative. By appointing the person named below as my personal representative, I understand that I am authorizing Bene-Flex Hawaii, Inc. to give this person access to my confidential account information and medical/dental records, and the right to speak with to Bene-Flex Hawaii, Inc. about my account.

*P.O. Box 459; Kailua, HI 96734-0459*

*Telephone: (808) 395-0020; Fax: (808) 263-0508; e-mail: beneflex.hawaii@verizon.net*

3. I represent that the person named below has agreed to act as my personal representative. I understand that my authorization will remain in effect until my participation is cancelled or I revoke my authorization in writing.

Personal Representative Information

First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Relationship to the employee participant: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Relationship to the employee participant: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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I, \_\_\_\_\_, hereby authorize the employee participant as stated on the front side of this form to be my personal representative. (Please fill out below)

First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
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I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this authorization. I understand that by signing this form I am confirming my authorization for the request and release of my confidential account information as stated within this form.

Employee Participant's Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

**Please submit this form to:**

**Bene-Flex Hawaii, Inc., P.O. Box 459, Kailua, HI 96734.**

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For Bene-Flex Hawaii, Inc. use only:

Date Received: \_\_\_\_\_ Received by: \_\_\_\_\_