Spackenkill Teachers' Association Benefit Trust

APPOINTMENT OF PERSONAL REPRESENTATIVE

Name and address of individual:

____

____

Phone: (____) ________________

I hereby designate the following person as my personal representative (name and address):

____

____

Phone: (____) ________________

Relationship to individual: ____

I hereby authorize the above named personal representative to act for me in receiving any protected health information ("PHI") that may be provided to me as a participant or beneficiary of the Plan.

OR

I hereby authorize my personal representative to act for me in receiving the following PHI to conduct the following functions on my behalf:

____

____

I understand that this appointment is subject to the Plan's approval. If approved, this appointment will remain in effect unless revoked. I understand that I have the right to revoke this appointment at any time by submitting to the Plan, in writing, a statement indicating that intent.

Signature: ____________________________ Date: ________________
Individual

Signature: ____________________________ Date: ________________
Personal Representative