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.

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 ...ke this designation at any time with written notice to Farm Bureau Health Plans.

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

MEMBER INFORMATION (REQUIRED) – PLEASE PRINT

	MI:	Last Name:
Address:		City, State, Zip:
Date of Birth:	Social Security #:	Identification #:
	E-mail Address:	

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

PERSONAL REPRESENTATIVE – PLEASE PRINT

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

Complete only if more than one representative is needed.

OPTIONAL REPRESENTATIVE – PLEASE PRINT

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

OPTIONAL REPRESENTATIVE – PLEASE PRINT

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

Sign here if you are the ADULT MEMBER listed above.

SIGNATURE (REQUIRED)

...ned above be allowed access to my protected health information. I understand that I may revoke this designation ...g a written notice to Farm Bureau Health Plans.

_____ _____

...nature **Date**

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.

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

_____ _____ _____

...ian/POA **Relationship to Member** **Date**

...his designation, this form must be complete and signed by the member. Incomplete forms will not be accepted. **Return ... Bureau Health Plans Privacy Office, PO Box 313, Columbia, TN 38402-0313, or email to privacyforms@fbhp.com.**

For questions, call the Privacy Office at 931-560-0041, Ext. 3115

YOU ARE ENTITLED TO A COPY OF THIS REQUEST

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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 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:

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

OPTIONAL REPRESENTATIVE – 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, or email to privacyforms@fbhp.com.**

For questions, call the Privacy Office at 931-560-0041, Ext. 3115
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