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 insured's Farm Bureau Health Plans ("FBHP") coverage and claims information including protected health information. Only one insured may be listed per form.

FARM BUREAU HEALTH PLANS
PERSONAL REPRESENTATIVE DESIGNATION (O65)

You have the right to request that Farm Bureau Health Plans ("FBHP") 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 ... You may revoke this designation at any time with written notice to FBHP.

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

INSURED 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 insured's health information.

PERSONAL REPRESENTATIVE – PLEASE PRINT

	MI:	Last Name:
Address:		City, State, Zip:
	Telephone:	Relationship to Insured:

Complete only if more than one representative is needed.

OPTIONAL REPRESENTATIVE – PLEASE PRINT

	MI:	Last Name:
Address:		City, State, Zip:
	Telephone:	Relationship to Insured:

Sign here if you are the INSURED listed above.

SIGNATURE (REQUIRED)

...amed above be allowed access to my protected health information. I understand that I may revoke this designation ...ng a written notice to FBHP.

_____ _____

Insured Signature **Date**

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

Sign here if you are:
POWER OF ATTORNEY/CONSERVATOR
- Papers are required if not already on file.

_____ _____ _____

...esentative **Relationship to Insured** **Date**

In order to process this designation, this form must be complete and signed by the insured. Incomplete forms will not be accepted. **Return this form to the FBHP Privacy Office, PO Box 313, Columbia, TN 38402-0313, or email to privacyforms@fbhp.com.**

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

YOU ARE ENTITLED TO A COPY OF THIS REQUEST

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PERSONAL REPRESENTATIVE DESIGNATION (O65)

You have the right to request that Farm Bureau Health Plans ("FBHP") 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 FBHP Privacy Office. You may revoke this designation at any time with written notice to FBHP.

INSURED 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 Insured:

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

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 FBHP.

_____ _____

Insured Signature **Date**

If the insured 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 Legal Representative **Relationship to Insured** **Date**

In order to process this designation, this form must be complete and signed by the insured. Incomplete forms will not be accepted. **Return this form to the FBHP Privacy Office, PO Box 313, Columbia, TN 38402-0313, or email to privacyforms@fbhp.com.**

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