

**CIGNA International Expatriate Benefits\* HIPAA Request for Personal Representative**

This form will allow me, as a CIGNA International Expatriate Benefits member/participant, to designate another person as my Personal Representative.

When it has been verified that an individual has authority under applicable state and/or other applicable law to act as the Personal Representative of a CIGNA International Expatriate Benefits member/participant, CIGNA International Expatriate Benefits will treat that person as the member/participant with respect to the disclosure of PHI and individual's rights under the HIPAA Privacy Rule. CIGNA International Expatriate Benefits will only treat the personal representative as the member/participant to the extent of his or her authority as described below. When the Personal Representative authority ends, the member/participant will need to contact the Privacy Office in writing.

**Identification of member/participant requesting a Personal Representative: The following information is needed to ensure we are releasing your information to the Personal Representative.**

Name of Member/participant requesting Personal Representative \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Member # \_\_\_\_\_  
Subscriber's Name (if different from member) \_\_\_\_\_  
Relationship to Member \_\_\_\_\_  
Subscriber's Employer Name \_\_\_\_\_  
Subscriber's Member Number \_\_\_\_\_

**Identification of Personal Representative: The following information is needed to ensure we are releasing your information to the Personal Representative you have designated.**

Name of Personal Representative \_\_\_\_\_  
Date of Birth (used for verification purposes on phone inquiries) \_\_\_\_\_  
Social Security # (used for verification purposes on phone inquiries) \_\_\_\_\_  
Address \_\_\_\_\_  
Relationship to Member \_\_\_\_\_

**Address where communications regarding this member/participant should be sent**

\_\_\_\_\_

**Verification Questions that Personal Representative must provide to access Individually Identifiable Health Information of the member/participant:**

Password \_\_\_\_\_

**Description of nature of representation and limits thereon (attach supporting documentation such as court orders, Healthcare Power of Attorney, etc):** \_\_\_\_\_

By signing this form, I hereby authorize CIGNA International Expatriate Benefits to disclose the information according to the terms set forth herein. I understand that any form returned to CIGNA International Expatriate Benefits incomplete will be returned to me for completion and the release of information to a Personal Representative will not occur until I complete all necessary information and such is received and processed by CIGNA International Expatriate Benefits.

I understand that if either I, as a member /participant or my group subscriber changes health care benefits coverage or employers that I will need to resubmit this request. I understand if I have previously submitted a HIPAA Privacy Confidential Communication request, my request for Personal Representative will take priority over such a request. The most recently received and processed request will be utilized for all communication purposes. I understand that CIGNA International Expatriate Benefits will review this request and may reject this request, and I will receive notification of approval or denial of this request. If denied, the notice will be sent to me, as the member/participant, and not to the Personal Representative I have listed.

***I understand that I may revoke this request at any time by sending a written request to do so to the following address:***  
Privacy Office, CIGNA International Expatriate Benefits, 590 Naamans Road, Claymont, DE 19703.

I have read and understand the above information:

Date \_\_\_\_\_ Signature of authorizing member/participant \_\_\_\_\_

If patient is unable to give consent because of physical condition or age, complete the following: Patient is a minor of \_\_\_\_\_ years of age or is unable to give consent, because \_\_\_\_\_

Signature of Parent/Guardian/POA \_\_\_\_\_ Relationship \_\_\_\_\_

**To safeguard your privacy and insure no one other than the person you designate receives your Individually Identifiable Health Information, this request must be notarized. (Notary services can often be provided free of charge at a bank with whom you maintain an account).**

**Note: Notary Public Signature is a requirement for members/participants that are located in the United States Only!**

Date \_\_\_\_\_ Notary Public Signature: \_\_\_\_\_ Notary Public Printed: \_\_\_\_\_

My Commission expires on: \_\_\_\_\_

**Notary Public Seal:**

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