CIGNA Medicare Rx® (PDP)

Medicare Part D Prescription Drug Plans

Personal Representative Request

The purpose of implementing a Personal Representative is to enable another individual to act on your behalf with respect to:

- making decisions about your health benefits;
- requesting and/or disclosing your Private Health Information; and
- exercising all of the rights you have under your health benefit plan.

A Personal Representative may either be legally appointed, or designated by a Member to act on his or her behalf:

- When a Personal Representative has been legally appointed, the Personal Representative should complete and sign this form. Supporting legal documentation, such as a power-of-attorney that indicates full health care decision-making authority or guardianship papers, must be submitted with this form.
- When a Personal Representative is being designated by a Member, the Member needs to sign this form in the presence of a Notary Public.

Important: Except for mail order pharmacy materials and medications, all Member mailings will be directed to the Personal Representative's address.

Home-delivery pharmacies will continue to send the medications, accompanying information and other communications directly to the Member (not to the Personal Representative) at the address the pharmacy has on file for the Member. If medications and communications are to be sent to the Personal Representative, please notify your mail order pharmacy directly.

The Member retains his or her right to act on his or her own behalf unless CIGNA Medicare Services[SM] receives legal documentation dictating otherwise.

Note: If your request is granted, it will affect only written and oral communications from CIGNA Medicare Services. If you also wish another group health plan, physician or anyone outside of CIGNA Medicare Services to make this change, you must obtain their agreement separately.

VERIFICATION – (Please Print)

Identification of Member: *(The following information is needed for verification.)*

Name of Member: ______________________________ Date of Birth: ____________________

Phone Number where we can reach you if we need to contact you to process your request (required):

____

Current Address on file: ____

Medicare ID #: ____________________ Member ID card # (if applicable): ____________________

Please Complete Next Page

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Identification of Personal Representative:

Name of Personal Representative: (only one person can be named) ______________________________

Relationship to Member: ____

Date of Birth of Personal Representative: (answer in the following 8-digit format: 11231949 for November 23, 1949) ___ ___ ___ ___ ___ ___ ___ ___.

Phone Number: (________) ________________________.

Address where communications about this Member should be sent: ______________________________

____

What is the reason for this request? ____

VERIFICATION QUESTIONS FOR PERSONAL REPRESENTATIVE

(In this section "You" and Your" refer to the Personal Representative.)

The answers you provide below will be used to verify your identity if you call for Private Health Information about the Member. Note that we ask these questions because the answers should be easy for you to remember, but you may enter other numbers as described below.

Last 4 digits of your favorite credit card (you may use any four digit number): ___ ___ ___ ___

What is your mother's date of birth? (answer in the following 8-digit format: 11231949 for November 23, 1949): ___ ___ ___ ___ ___ ___ ___ ___.

You may use any date, however, it cannot be a future date, and it must be a legitimate calendar date. For example, we cannot accept 11361949 (November 36, 1949) because there are not 36 days in November. We also cannot accept 11232010 (November 23, 2010) because 2010 is a future date.

- Please DO NOT provide anyone else with the answers to these questions.

PLEASE NOTE

- If the information on this form is not complete, CIGNA Medicare Services will return the form to you, and this request will not be considered until CIGNA Medicare Services receives complete information.
- Any previous request to send information to an alternate address will be disregarded. All future Member correspondence will be sent to the address specified above.
- You may change or revoke this request by sending a written request to CIGNA Medicare Services, at the address on the following page. You can obtain a Change/Revoke form by calling CIGNA Member Services at the number on your CIGNA Medicare Services ID card.

SIGNATURE AND NOTARIZATION

Personal Representatives who are appointed by a court order or other legal documentation, please complete section A.

Personal Representatives who are designated by a Member, please proceed to sections B and C.

A. Personal Representatives who are legally appointed:

I have read and understand the above information. I acknowledge that by signing this form I have the legal authority to act on behalf of the Member.

Please Complete Next Page

Signature of Personal Representative: ______________________________ Date: ____________________

To safeguard privacy and help make sure no one other than the person whom the Member designates receives Private Health Information, this request must be submitted with appropriate supporting legal documentation.

B. Personal Representatives designated by a Member

To safeguard privacy and help make sure no one other than the person whom the Member designates receives Private Health Information, this request must be signed by the Member and be notarized. (Notary services often can be provided free at a bank where you have an account).

I have read and understand the above information. I acknowledge that by signing this form I authorize CIGNA Medicare Services to treat my Personal Representative as myself.

Signature of Member/Parent/Guardian (This line is for the Member to sign, authorizing the Personal Representative.)

____ Date: ____________________

If request is made by a Parent/Guardian for a minor child, complete the following:

Member is a minor _____ years of age. If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

C. Notary Public Signature

State of)
) ss.
County of)

On this the _______ day of _________________________________, 20__ __, before me, (Notary Public), the undersigned officer, personally appeared ____(Member), known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledges that (s)he executed the same for the purposes therein contained.

In witness whereof I hereunto set my hand.

____ ____________________________

Notary Public My Commission Expires

Please maintain a copy of this form for your records.

Please Return This Completed Form To:

CIGNA Medicare Services • PO Box 269005 • Weston, FL 33326-9927

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