Cigna Healthcare, Global Health Benefits℠
HIPAA Request for Personal Representative

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 protected 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 customer 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.

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

Cigna Healthcare, Global Health Benefits will only treat the personal representative as the customer/participant to the extent of his or her authority as described below. When the Personal Representative authority ends, the customer/participant will need to contact the Privacy Office in writing.

Identification of customer/participant requesting a Personal Representative: The following information is needed to ensure we are releasing <u>your</u> information to the Personal Representative.

Name of Customer/Participant Requesting Personal Representative | Date of Birth | Customer ID Number

Subscriber's Name (if different from Customer) | Relationship to Customer

Subscriber's Employer Name | Subscriber's ID Number

Telephone Number | Email Address

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 Number or National ID Number *(used for verification purposes on phone inquiries)*

Address | Relationship to Customer

Please Complete Next Page

Address where communications regarding this customer/participant should be sent:

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

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

(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 protected health information about the Customer. 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.

4-digit PIN (you may use any 4-digit number): _____

What is your mother's date of birth? _____

(Please 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 11232030 (November 23, 2030) because 2030 is a future date.

- Please DO NOT provide anyone else with the answers to these questions.
- You should keep a copy of this form for reference

Please Note

- If the information on this form is not complete, Cigna Healthcare, Global Health Benefits will return the form to you, and this request will not be considered until Cigna Healthcare, Global Health Benefits receives complete information.
- If your Customer ID or date of birth is changed, another form will need to be completed at that time.
- If either the Customer or Group changes to a different type of health care benefits coverage provided by Cigna Healthcare, Global Health Benefits, another form will need to be completed at that time.
- Any previous request to send information to an alternate address will be disregarded. All future Customer correspondence will be sent to the address specified above.
- You may change or revoke this request by sending a written request to Cigna Healthcare, Global Health Benefits at the address on the following page. You can obtain a Change/Revoke form by calling Cigna Healthcare, Global Health Benefits Customer Service at the number on your ID card.

Please Complete Next Page

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

Personal Representatives who are designated by a Customer, please proceed to section B.

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 Customer. Signature of Personal Representative: _____Date:_____

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

B. Personal Representatives designated by a Customer to safeguard privacy and help make sure no one other than the person whom the Customer designates receives Protected Health Information, this request must be signed by the Customer. I have read and understand the above information. I acknowledge that by signing this form I authorize Cigna Healthcare to treat my Personal Representative as myself.

   Signature of Customer/Parent/Guardian (This line is for the Customer to sign, authorizing the Personal Representative:

   _____ Date: _____

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

Please complete and return this form to the following address:

Privacy Office
Cigna Healthcare, Global Health Benefits
300 Bellevue Parkway
Wilmington, Delaware 19809

I understand that I may revoke this authorization by sending a written request to this same address.

Clear Form