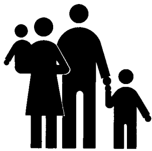

SOUTHERN CALIFORNIA UNITED FOOD & COMMERCIAL WORKERS UNIONS AND DRUG EMPLOYERS TRUST FUNDS

2220 HYPERION AVENUE • LOS ANGELES, CALIFORNIA 90027

TEL (323) 666-8910 • FAX (323) 663-9495 • WWW.UFCWDRUGTRUST.ORG

Administrative offices for:

SOUTHERN CALIFORNIA UNITED FOOD & COMMERCIAL WORKERS UNIONS AND DRUG EMPLOYERS PENSION FUND

SOUTHERN CALIFORNIA DRUG BENEFIT FUND

Appointment of Authorized Representative

An Authorized Representative is an individual you appoint to act on your behalf in filing and pursuing a claim for benefits (a "claim") and/or appealing a denied claim (an "appeal") under the Southern California United Food and Commercial Workers Unions and Drug Employers Pension Fund (the "Pension Fund") or the Southern California Drug Benefit Fund (the "Benefit Fund").

This form is being used to appoint an Authorized Representative to handle a claim and/or appeal under the following Fund (*please check one*):

☐ The Southern California United Food and Commercial Workers Unions and Drug Employers Pension Fund

☐ The Southern California Drug Benefit Fund

Please note that you can only appoint an individual (a person) as your Authorized Representative, not an entity (such as a corporation).

I, ____, hereby appoint the following individual,
(Claimant's Name)

______________________________________, to act on my behalf (or, if the participant is a minor enrolled
(Authorized Representative's Name)

in the Benefit Fund, on behalf of ____), in connection with
(Minor Participant's Name)

either *(check one box only)*:

☐ The following claim(s) and/or appeal(s):
Please provide detailed information (specify event(s) and/or date(s) of service, if applicable). Attach additional sheets, if necessary.

____

____

☐ Any present or future claim and/or appeal (until this form expires).

1. I understand that as a result of this appointment: (1) the Fund may disclose and release to my Authorized Representative information relevant to the claim(s) and/or appeal(s) specified above (including, if applicable, any approvals or authorizations that are required before medical services are provided under the Benefit Fund) in accordance with ERISA section 503 and applicable claims procedure regulations; and (2) the Fund is not required to disclose information described in ERISA section 104(b)(2) to my Authorized Representative unless such information is also subject to disclosure under ERISA section 503.

2. This Appointment of Authorized Representative will expire (*insert expiration date or event relating to you personally*): _______________. If no expiration date or event is specified, this Appointment of Authorized Representative will remain in effect until the earlier of: (1) a final decision by the Fund's Appeals Committee with respect to the claim(s) and/or appeal(s) specified above; (2) one year from the date of my signature; or (3) until revoked by me in writing.

3. All information and notifications from the Fund (e.g., EOBs, requests for documents, appeal-related notices) that relate to the claim(s) and/or appeal(s) specified above will be directed to you and to your Authorized Representative.

4. *For Health Claims/Appeals only*: Notwithstanding paragraph 1, above, I understand that I am required to complete and submit a PHI Authorization Form in order for the Benefit Fund to disclose my protected health information ("PHI") to my Authorized Representative, unless my Authorized Representative is my Personal Representative under HIPAA.

______________________________ ____________________
Claimant's Signature *Date*

Accepted:

______________________________ ____________________
Authorized Representative's Signature *Date*

The Southern California Drug Benefit Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-323-666-8910.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-323-666-8910。