G.M.P. – Employers Retiree Trust
Personal Representative Authorization

Section #1: Purpose

This form allows you (the "Participant") to give the G.M.P. – Employers Retiree Trust (the "Trust") permission to disclose and discuss your protected health information ("PHI") with a person that will act as your Personal Representative. The information covered by this authorization is protected health information, including identification of treating providers of care; diagnoses; procedures; and personal information, such as your date of birth and mailing address.

Each person who wishes to name a Personal Representative must complete an authorization form. For example, if you expect your spouse to call the Trust on your behalf, you need to fill out this form. If you do not wish to name a Personal Representative, do not complete this form. **You are not required to name a Personal Representative,** but if you do not, the Trust will not release your PHI to someone who may call or write on your behalf. Your Personal Representative may be anyone of your choosing, such as a spouse, child, friend, or union representative. You must provide the information requested in Section #3 for each person before the Trust can treat that person as your Personal Representative. If you need additional forms, you may copy this form, or request additional forms from the Trust Office.

Please note: This authorization does not give your Personal Representative authority, either implied or direct, over any treatment or direct care decisions. Also, the Trust will not condition enrollment, eligibility for benefits, or benefits payments on your completion of this form.

Section #2: Participant's Information

I authorize the Trust to treat the person(s) named in Section #3 as my Personal Representative(s), subject to the rights and the restrictions, if any, described in Section #3.

My Name: ____ My Birth Date: ____ / ____ / ________
(print name) MM / DD / YEAR

I certify that I am (check all that apply):

- ☐ A participant
- ☐ A participant's spouse or surviving spouse
- ☐ Another dependent of a participant

You can contact me at:

Daytime Telephone Number: (______) ______ - ________ E-mail: ___________________________

Name of Participant: ____
(print name)

Participant's Social Security No.: ______ - ______ - ________ Participant's Birth Date: ____ / ____ / ________
MM / DD / YEAR

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Section #3: Authorized Use and/or Disclosure

I understand that the Trust's privacy practice is to not disclose my personal health information, except for the purpose of treatment, payment, and health care operations, or as required by law, without my written authorization. For this reason, **I authorize the Trust to disclose and discuss my protected health information with the person(s) named in Section #3** for the purpose of assisting with or facilitating the payment of my benefits. Unless I have stated restrictions in Section #3, I also allow my Personal Representative the following rights: the right to request amendment of my PHI; the right to request an accounting of disclosures of my PHI; and the right to request restrictions on disclosure of my PHI. I understand that if my Personal Representative is not a health plan, a health care provider, or another entity subject to federal or applicable state privacy laws, those laws may no longer protect my personal health information, and my Personal Representative may further disclose my PHI without my authorization. I acknowledge that my authorization is voluntary.

I understand that I have the right to limit the information you release under this authorization. For example, I may limit a Personal Representative's access to information only about a particular provider or diagnosis/disease; or I may allow a Personal Representative access to everything except information from a particular provider or about a particular diagnosis/disease. Any such limitations must be described in this section under *Restrictions.*

Personal Representative #1

Full Name: ____ Phone Number: (______) ______ - ________
(please print)

Relationship to You: _______________________________________ *[such as spouse, child, friend, etc.]*

Personal Representative #2

Full Name: ____ Phone Number: (______) ______ - ________
(please print)

Relationship to You: _______________________________________ *[such as spouse, child, friend, etc.]*

Restrictions: ____

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Section #4: Expiration and Revocation

This authorization to release information to my Personal Representative will automatically expire two (2) years after the date my coverage under the Trust ends.

I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish any person named in Section #3 to remain my Personal Representative, I must revoke my authorization by giving written notice of my decision to the Privacy Officer at the address shown below. I understand that my revocation of this authorization will not affect any action that you have taken or information that you have already released, based upon the authorization, before you receive my request to revoke authorization.

PRIVACY OFFICER
G.M.P. – Employers Retiree Trust
5245 Big Pine Way, S.E.
Fort Myers, Florida 33907-5998

Section #5: Signature/Authorization

I, ____ (print name), have had full opportunity to read and consider the content of this form. I understand that by signing this form, I am confirming my authorization that the Trust may disclose my protected health information to the person(s) named on this form, for the purpose described above.

____ ____ / ____ / ________

Signature MM / DD / YEAR

Please complete and sign this form, and return it to our Privacy Officer, at the address shown in Section #4. You are entitled to a copy of this completed form.