CONNECTICUT LABORERS' FUNDS

Appointment of Personal Representative

I, _____

[Name of Participant or Beneficiary]

Mailing address: _____

Phone: (_____) _____

Last Four (4) Digits of your Social Security Number: _____

Appointment of Personal Representative

I hereby designate:

_____

[Name of Personal Representative]

Mailing address: _____

Phone: (_____) _____

Relationship to Participant or Beneficiary:

_____

to act on my behalf or on behalf of: _____ *[Name of Dependent]*

- ☐ *I authorize my Personal Representative to act for me and/or my dependent in receiving any information that is (or would be) provided to me as a participant/beneficiary of the Plan, including but not limited to, any information that relates to my claim for coverage or benefits under the Plan and any individual rights that I have regarding my protected health information under HIPAA.*

or

- ☐ *I authorize my Personal Representative to act for me and for my covered spouse and dependents (if named above) in receiving the following protected health information to conduct the following functions on my behalf:*

_____

_____

I understand that this designation is subject to approval by the Plan. I also understand that, once approved, this designation will remain in effect unless I revoke it. I understand that I have the right to revoke this designation at any time by submitting a signed statement to that effect to the Fund Office.

I certify that I have reviewed the Plan's Policy for Recognition of Personal Representative.

_____ _____

Participant or Beneficiary's Signature *Date*

_____ _____

_____ _____

Personal Representative's Signature *Date*

CONNECTICUT LABORERS' FUNDS
Revocation of Personal Representative

Revocation of Personal Representative

Note: The following revocation will not take effect until received by the Fund.

I hereby revoke my appointment of _____ *as my Personal Representative effective* _____.

I certify that I have reviewed the Plan's Policy for Recognition of Personal Representative.

Last Four (4) Digits of your Social Security Number: _____

_____
Printed Name

_____ _____
Participant or Beneficiary's Signature *Date*