Cigna Global Health Benefits℠ HIPAA Request for Personal Representative

This form will allow me, as a Cigna Global Health Benefits member/participant, to designate another person as my Personal Representative.

When it has been verified that an individual has authority under applicable state and/or other applicable law to act as the Personal Representative of a Cigna Global Health Benefits member/participant, Cigna Global Health Benefits will treat that person as the member/participant with respect to the disclosure of PHI and individual's rights under the HIPAA Privacy Rule. Cigna Global Health Benefits will only treat the personal representative as the member/participant to the extent of his or her authority as described below. When the Personal Representative authority ends, the member/participant will need to contact the Privacy Office in writing.

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

Name of Member/Participant Requesting Personal Representative | Date of Birth | Member #

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

Subscriber's Employer Name | Subscriber's Member Number

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 # *(used for verification purposes on phone inquiries)*

Address | Relationship to Member

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

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

Password

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

By signing this form, I hereby authorize Cigna Global Health Benefits to disclose the information according to the terms set forth herein. I understand that any form returned to Cigna Global Health Benefits incomplete will be returned to me for completion and the release of information to a Personal Representative will not occur until I complete all necessary information and such is received and processed by Cigna Global Health Benefits.

I understand that if either I, as a member/participant or my group subscriber changes health care benefits coverage or employers that I will need to resubmit this request. I understand if I have previously submitted a HIPAA Privacy Confidential Communication request, my request for Personal Representative will take priority over such a request. The most recently received and processed request will be utilized for all communication purposes. I understand that Cigna Global Health Benefits will review this request and may reject this request, and I will receive notification of approval or denial of this request. If denied, the notice will be sent to me, as the member/participant, and not to the Personal Representative I have listed.

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I understand that I may revoke this authorization by sending a written request to do so to the following address:

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

I have read and understand the above information:

Date: ________________ Signature of Authorizing Member/Participant: ____

If patient is unable to give consent because of physical condition or age, complete the following: Patient is a minor of ______ years of age or is unable to give consent, because: ____

Signature of Parent/Guardian/POA: ____ Relationship: ___________________

To safeguard your privacy and insure no one other than the person you designate receives your Individually Identifiable Health Information, this request must be notarized. (Notary services can often be provided free of charge at a bank with whom you maintain an account).

Note: Notary Public Signature is a requirement for members/participants that are located in the United States only!

Date: ________________ Notary Public Signature: ____

Notary Public Printed: ____ My Commission expires on: _________________

Notary Public Seal:

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