

*Pension, Health, and 401(k) Trust Funds*

Executive Director ARTHUR DRECHSLER

# EQUITY-LEAGUE

165 WEST 46<sup>th</sup> STREET, (14<sup>th</sup> FLOOR)  
NEW YORK, N.Y. 10036-2582  
(212) 869-9380 FAX (212) 869-3323

## **Equity-League Health Trust Fund (the "Plan") Appointment of Personal Representative Form<sup>1</sup>**

I, \_\_\_\_\_ [Name of Participant or Beneficiary]

Mailing address: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_

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 for my covered spouse, domestic partner or dependent, if named above,] 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.

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. This form must be notarized or include a photocopy of your union membership identification card or some other form of identification (i.e., driver's license or passport).

\_\_\_\_\_  
Participant/Beneficiary's Signature

\_\_\_\_\_  
Date

<sup>1</sup> This form will also satisfy the Plan's obligation under ERISA's claims and appeals regulation to have a process for recognizing "authorized" representatives in dealing with specific claims.