

**APPOINTMENT OF PERSONAL REPRESENTATIVE FOR HEALTH PAYMENT PURPOSES**

I voluntarily appoint the individual or individuals named below as my authorized representative to act for me in all payment matters (as defined by HIPAA), including, but not limited to questions regarding enrollment, claims status, utilization review, pre-existing conditions, coordination of benefits, and subrogation, except as specifically provided below.

This appointment becomes effective on the date signed, and will remain in effect until I notify either my employer or Nyhart that this appointment is terminated. Notice of termination may be written or verbal.

_____ My Name (Printed)	_____ Name of My Representative (Printed)
_____ Signature	_____ Relationship to Me
_____ Employee's Social Security Number	_____ Representative's Date of Birth
_____ Name of Employer	_____ _____
_____ Group Number	_____ Representative's Address
_____ Date	
_____ List Any Matters in Which Representative May Not Act:	_____ Name of Additional Representative (Optional)
_____ _____	_____ Relationship to Me
_____ Signature of Witness*	_____ Representative's Date of Birth
_____ Signature of Witness*	_____ _____
	_____ Representative's Address

\*Witnesses must be at least 18 years old. They may not be your blood relative, or a person you have named as your representative.

**Return to:**  
**Nyhart**  
**Attn: Customer Service**  
**P. O. Box 80884**  
**Indianapolis, IN 46280-0884**  
**Or fax to Nyhart at 317-803-7890**