Humana Inc.
APPOINTMENT OF AUTHORIZED REPRESENTATIVE FORM

______________________________ ______________________________

Member Name **Member ID Number**

I, ______________________________ , appoint ______________________________

Name of Member Name of Authorized Representative

to act on behalf of ______________________________

Name of Member

in connection with any claim for coverage or benefits, including receipt of any approvals or authorizations that are required before medical services. I authorize my representative to receive any and all information that is provided to me, and to act for me and for my minor dependent, if named above as the patient, in providing any information to the group health plan that relates to any claim for coverage or benefits under this group health plan.

______________________________ ______________________________

Signature of Member **Date**

Address: ______________________________ Telephone Number: ______________________________

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I, ______________________________ , hereby accept the above appointment.

Name of Authorized Representative

I am a/an ______________________________

Relationship to member

______________________________ ______________________________

Signature of Authorized Representative **Date**

Address: ______________________________ Telephone Number: ______________________________

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