Southern California
United Food & Commercial Workers Unions and
Food Employers Joint Benefit Funds Administration, LLC
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Appointment of Authorized Representative

An Authorized Representative is an individual you appoint to act on your behalf in filing and pursuing a claim for benefits (a "claim") and/or appealing a denied claim (an "appeal") under the Southern California United Food and Commercial Workers Unions and Food Employers Joint Pension Fund (the "Pension Fund") or the United Food and Commercial Workers Unions and Food Employers Benefit Fund (the "Benefit Fund") (collectively, the "Funds").

This form is being used to appoint an Authorized Representative to handle a claim and/or appeal under the following Fund (*please check one*):

☐ The Pension Fund

☐ The Benefit Fund

Please note that you can only appoint an individual (a person) as your Authorized Representative, not an entity (such as a corporation).

I, _____, hereby appoint the following individual,
(Claimant's Name)

_____, to act on my behalf (or, if the participant is a minor, on
(Authorized Representative's Name)

behalf of _____), in connection with either (check one box only):
(Minor Participant's Name)

☐ The following claim(s) and/or appeal(s):
Please provide detailed information (specify event(s) and/or date(s) of service, if applicable). Attach additional sheets, if necessary.

_____

_____

☐ Any present or future claim and/or appeal (until this form expires).

1. I understand that as a result of this appointment, the Fund selected above: (1) may rely on the directions of, and correspond directly with, my Authorized Representative with respect to the claim(s) and/or appeal(s) specified above; (2) may disclose and release to my Authorized Representative any information relevant to the claim(s) and/or appeal(s) specified above (including, if applicable, any approvals or authorizations that are required before medical services are provided under the Benefit Fund) in accordance with ERISA section 503 and applicable claims procedure regulations; and (3) is not required to disclose information described in ERISA section 104(b)(2) to my Authorized Representative, unless such information is also subject to disclosure under ERISA section 503.

2. This Appointment of Authorized Representative will expire (*insert expiration date or event relating to you personally*): _____. If no expiration date or event is specified, this Appointment of Authorized Representative will remain in effect until the earlier of: (1) a final decision by the Funds' Appeals Committee with respect to the claim(s) and/or appeal(s) specified above; (2) one year from the date of my signature; or (3) until revoked by me in writing.

3. All information and notifications from the Funds (e.g., EOBs, requests for documents, appeal-related notices) that relate to the claim(s) and/or appeal(s) specified above will be directed to your Authorized Representative with a courtesy copy sent to your attention.

4. *For Health Claims/Appeals under the Benefit Fund only*: Notwithstanding paragraph 1, above, I understand that I am required to complete and submit a PHI Authorization form in order for the Benefit Fund to disclose my protected health information ("PHI") to my Authorized Representative, unless the Benefit Fund has already received a valid HIPAA Personal Representative Form establishing my Authorized Representative as my Personal Representative under HIPAA. A HIPAA Personal Representative Form generally is not necessary to establish Personal Representative status with respect to a minor child who is a covered dependent in the Benefit Fund if: (1) the Personal Representative is also the minor child's parent or legal guardian, and (2) the Personal Representative also participates in the Benefit Fund.

_____ _____

Claimant's Signature *Date*

Accepted:

_____ _____

Authorized Representative's Signature *Date*