Southern California
United Food & Commercial Workers Unions and
Food Employers Joint Benefit Funds Administration, LLC
6425 Katella Avenue, Cypress, CA 90630-5238
PO Box 6010, Cypress, CA 90630-0010
714-220-2297 • 562-408-2715 • 877-284-2320
scufcwfunds.com

NOTIFICATION OF HIPAA PERSONAL REPRESENTATIVE

Instructions: *This form should be completed by the Personal Representative of an Individual.*

- An **Individual** is a person who participates in the United Food and Commercial Workers Unions & Food Employers Benefit Fund (the "Plan") as a Participant or a spouse or child of a Participant.

- A **Personal Representative** under HIPAA is a person who is entitled, under applicable law, to decide and act on behalf of the Individual: (1) with respect to that Individual's health care; and (2) for the purposes of exercising certain rights relating to the Individual's protected health information. **Personal Representative status is a legal status determined in accordance with applicable law – you cannot use this form to appoint a Personal Representative.**

Please note: This form generally is not necessary to establish Personal Representative status for an Individual who is a minor child if: (1) you are the minor child's parent or legal guardian; and (2) you also participate in the Plan.

Individual's name:______________________________________ Individual's birthdate:______________________

Participant's name*: _____________________________ Participant's Fund ID**:_____________

**To be completed if the Individual is not a Participant*
***If you don't know the Participant's Fund ID, please provide the last four digits of his/her SSN*

Personal Representative's name:____

Personal Representative's contact information: ____
Street

________________________________ ____________ ___________
City State Zip Code

____
Phone Number

Personal Representative's relationship to the Individual (select one):

____ Parent/guardian of the Individual (who is a minor child) – *Attach a copy of the minor's birth certificate or proof of guardianship or other proof of authority to act on the minor's behalf.*

____ Power of attorney with authority to make health care decisions on behalf of the Individual – *Attach a copy of signed power of attorney form.*

____ Executor or administrator of the deceased Individual's estate – *Attach a current copy of letters of office or a certified copy of a court order evidencing your appointment.*

____ Other (describe your relationship to the Individual):______________________________________
Attach proof of your authority to make health care decisions on behalf of the Individual.

Read and sign the following statement:

I hereby certify that I am a person with legal authority to make health care decisions for the Individual listed above. I have attached the required documentation to establish my status as the Individual's Personal Representative under HIPAA. I certify that the information on this Notification of HIPAA Personal Representative form is true, correct, and accurate to the best of my knowledge. I understand that the Plan may request information, now or in the future, as deemed necessary to confirm my Personal Representative status. I will immediately notify the Plan of any change in my status as the Individual's Personal Representative.

Signature:____ Date:______________________

Send this completed form to the Plan at:

Privacy Officer
United Food and Commercial Workers
Unions & Food Employers Benefit Fund
6425 Katella Avenue
PO Box 6010
Cypress, California 90630
Fax: 714-220-2002

If you have questions about this form or about the requirements to establish Personal Representative status, contact the Plan at 714-220-2297 ext. 380.

For internal use only: ☐ Approved ☐ Denied
Date received:____