



REPRESENTATIVE FORM

Designating a Representative:

You may choose a Representative to help you with (1) applying for a waiver or reduction of premium, if you are a premium paying member, due to extreme financial hardship; (2) applying for a waiver of your copayment, if you are a non-premium paying member, due to extreme financial hardship; (3) requesting a health plan change; or (4) appealing any appealable action of the Commonwealth Health Insurance Connector Authority (the Connector). You may limit the authority of your Representative to one of the above listed responsibilities or allow your Representative to have authority over all responsibilities. By designating a Representative, you are authorizing the Connector to share your personal health information with that Representative.

Filling Out the Representative Form:

- If you are designating a Representative, you must fill out *Section I, A-D*.
- If you cannot designate in writing your chosen Representative due to your mental or physical condition, your Representative must fill out *Section I, A-C and Section II*.
- If your Representative has been appointed by law, they must fill out *Section I, A-C and Section III*.
- If your Representative is representing you due to your mental or physical condition *and* they have been appointed by law, they must fill out *Section I, A-C, Section II and Section III*.
- All Representatives must fill out Section IV.

Assistance with this Form:

Please mail or fax this Representative Form, and any other materials for us to consider. Keep a copy for your records.

*Commonwealth Care Customer Service Center
P.O. Box 120089 Boston, MA 02112-9914
1-877-MA-ENROLL Fax: 1-877-623-2155
Business Hours Monday-Friday 8am-5pm*

If you need assistance in completing this Form, please contact the Commonwealth Care Customer Service Center. Please note that only Connector approved formats will be accepted.

SECTION I:

A. Clearly Print Member Information

First Name Initial Last Name

Mailing Address

City State Zip

Home Address (if different)

Home Telephone Gender

Daytime Telephone (if different)

Date of Birth ID Number (Usually SS#)

B. Authorization

My Representative shall have the authority to be my Representative in the following matter(s):

- My Waiver Application My Appeal
 My Health Plan Change Request Form All

My permission to share information is good until the conclusion the matter indicated above or until _____ [insert date]

C. Name of Representative

Representative First Name Last Name

Representative Telephone Number

Representative Mailing Address

City State Zip

Name of Representative Organization/Business

Representative Relationship

D. Member Signature

I certify that I have read, or had read to me, the information on this form and that I understand my rights and responsibilities. I further authorize the release of my personal health information and other confidential data related to this representation to my designated Representative.

Signature (Sign) Date

First Name and Last Name (Print)

Who Can Be a Representative:

A Representative can be a friend, family member, relative, or other person who has a concern for your well-being and who agrees to help you. A Representative is a person you choose. The Connector will not choose your Representative.

If, because of a mental or physical condition, you cannot designate in writing whom you want to be your Representative, a person who is acting responsibly on your behalf can be your Representative if that person certifies that you are not able to fill out the application yourself, and that he or she is acting responsibly on your behalf.

A Representative can also be someone who has been appointed by law to act on your behalf or on behalf of your estate. Either you or this person must submit to the Connector a copy of the applicable legal document stating that this person is lawfully representing you or your estate. This person may be a legal guardian, conservator, holder of power of attorney, or health-care proxy, or an estate administrator or executor.

Dismissing a Representative:

Anytime you no longer want this person to be your Representative, you must send a letter stating this to: Commonwealth Care Customer Service Center, Attn: Representative Dismissal, P.O Box 120089, Boston, MA 02112-9914.

SECTION II. If Unable to Sign

I agree to be the designated Representative, for the named Individual, for the length of time as indicated on this Form. I further understand my duties and responsibilities as this named Individual's Representative in said matter(s) as selected in this Form and that this named Individual cannot provide written designation. I have also told this named Individual that he or she may remove me as Representative at any time as provided in this Form. I am also authorized to receive the named Individual's personal health information and other confidential data connected with this representation.

Representative Signature (Sign) Date

First Name and Last Name (Print)

SECTION III. If Appointed By Law

I am the legally designated Representative for the named Individual. I have included copies of applicable legal document(s) conferring legal representative status. I am also authorized to receive the named Individual's personal health information and other confidential data connected with this representation.

Legal Representative Signature (Sign) Date

First Name and Last Name (Print)

SECTION IV: Representative Disclosure

Representatives must answer the questions below. (Additional space is provided to the left.)

1. *Do you or did you receive any compensation of any form, by any individual or entity, other than the named Individual you are representing, for any and all actions taken on behalf of said Individual?*

YES NO (If checked yes, please describe)

2. *Do you or did you have any financial, contractual, legal, or other business interests with or in any health care provider or Commonwealth Care health plan, which has a relationship with the named Individual?*

YES NO (If checked yes, please describe)

I certify the information is complete and that I have disclosed any interests to the named Individual.

Representative Signature (Sign) Date