

Appointment of Personal Representative



I authorize the person named below to be my Personal Representative, to act on my behalf to make all decisions related to my Tufts Health Plan coverage, as if I were doing so myself. My Personal Representative may receive my health information from and disclose such information to Tufts Health Plan.

Member Name:	
Member ID#	<input style="width: 100%;" type="text"/>
Member Address:	
Member City/State/Zip:	
Member Date of Birth:	Member Phone #:

Name of Personal Representative:	
Relationship to Member:	Address:
	City/State/Zip
Phone	Email (optional)

This Personal Representative is being appointed to act on my behalf with regard to any matter related to my insurance coverage and benefits provided by Tufts Health Plan ("Plan"). This includes acting on my behalf to share my health information with the Plan and/or to request my health information from the Plan, as it relates to enrollment, premium payments, benefits, claims, address changes, PCP changes, requests for special communications, and/or assistance with complaints, grievances or appeals.

I understand that I have a right to revoke this appointment in writing at any time and to send my written revocation to Tufts Health Plan at the address listed below. This appointment will remain in effect indefinitely unless I specify an earlier expiration date here:

I represent that the signature below is my own and that I am authorized to sign this document.	
Member Signature: SIGN HERE →	<i>If an authorized representative is signing here, documentation verifying representation is required.</i>
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<i>Print Name</i>	<i>Date</i>
Relationship to Member, if signed by someone other than Member: <i>(documentation required) >>></i> <input style="width: 100%;" type="text"/>	
Personal Representative Signature <i>(indicates agreement to serve acting on behalf of the member)</i> SIGN HERE →	
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<i>Print Name</i>	<i>Date</i>

Please Fax this Completed Form to: 1-617-673-0380
or mail it to: Tufts Health Plan– Member Services,
705 Mt. Auburn St., P.O. Box 9170, Watertown, MA 02471-9170

If you have any questions about this form, please contact Member Services at: 1-800-462-0224 (TTD: 711). After hours and on holidays, please leave a message and a representative will return your call the next business day.