IATSE NATIONAL BENEFIT FUNDS

I.A.T.S.E. National Health and Welfare Fund

Appointment of Personal Representative

I, _____ [Name of Participant or Beneficiary]
(PLEASE PRINT)

_____ Participant's Social Security No.

Mailing Address: _____

Phone: (_____)_____

hereby designate: _____ [Name of Personal Representative]

Phone: (_____)_____

Relationship to Participant or Beneficiary _____ to act on my behalf

or on behalf of: _____ [Name of Dependent]

I authorize my Personal Representative to act for me [and for my covered spouse or dependent, if named above,] in receiving any information that is (or would be) provided to me as a participant/beneficiary of the Fund, including but not limited to, any information that relates to my claim for coverage or benefits under the Fund and any individual rights that I have regarding my protected health information under HIPAA.

I understand that this designation is subject to approval by the Fund. I also understand that, once approved, this designation will remain in effect unless I revoke it. I understand that I have the right to revoke this designation at any time by submitting a signed statement to that effect to the Fund Office.

I certify that I have reviewed the Fund's Policy for Recognition of Personal Representative.

_____ _____
Participant or Beneficiaries' Signature Date

_____ _____
Personal Representative's Signature Date

This form will also satisfy the Fund's obligation under ERSA's claims and appeals regulation to have a process for recognizing "authorized" representatives in dealing with specific claims.