

# FEDERAL

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## PRE-EXISTING CONDITION INSURANCE PLAN

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### AUTHORIZATION REPRESENTATIVE APPOINTMENT FORM

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_, whose address is  
(member name) (name)

\_\_\_\_\_ and telephone number is  
(street) (city) (state) (zip)

(\_\_\_\_\_) \_\_\_\_\_, to communicate with the Pre-Existing Condition Insurance Plan (PCIP), on  
my behalf regarding \_\_\_\_\_  
(list specific service, supply, prescription drug, equipment or treatment)

performed or to be performed on \_\_\_\_\_, 201\_\_ by \_\_\_\_\_.  
(date) (physician or health care provider)

I understand and agree that my Authorized Representative shall have the authority to represent  
me in all matters concerning my health claim.

I understand and agree that PCIP shall send all correspondence, notices and benefit determinations in  
connection with my health claim to the Authorized Representative. I further understand and agree that it will take  
PCIP a reasonable period, approximately thirty (30) days, to notify all its personnel about the termination of this  
appointment of the Authorized Representative and it is possible that the Company may communicate information  
about me to the Authorized Representative during this notification period.

This authorization shall remain void until I notify PCIP in writing to terminate it or until this health  
claim has not been resolved, whichever occurs first.

\_\_\_\_\_  
Policyholder Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Policyholder Name – Printed

\_\_\_\_\_  
(PCIP) Policyholder ID #