

**Group Insurance Trust of the
California Society of Certified Public Accountants
Personal Representative Form**

This form should be completed by the Personal Representative of a Health Plan participant.

A Personal Representative is a person entitled under applicable law to decide and act on behalf of a Health Plan participant with respect to the Health Plan participant's health care. A Personal Representative is entitled to act on behalf of the Health Plan participant for purposes of exercising certain rights relating to the Health Plan participant's health information. **Please note: This form is not necessary if: (i) you are the parent or legal guardian of a minor child who is a participant in a Health Plan; and (ii) you are also a participant in a Health Plan.**

Health Plan participant name: _____

Employee's name: _____ Employee's ID: _____

Personal Representative's name: _____

Best way to contact Representative: _____

Relationship to the Health Plan participant (select one):

- Parent/guardian of the minor Health Plan participant - *Attach a copy of the minor's birth certificate or proof of guardianship.*
- Power of attorney with authority to make health care decisions on behalf of the Health Plan participant - *Attach copy of signed power of attorney form.*
- Executor or administrator of the deceased Health Plan participant's estate - *Attach Letters Testamentary or other legal documents evidencing executor or administrator status.*
- Other (please describe your relationship to the Health Plan participant, and attach proof of your authority to make health care decisions on behalf of the Health Plan participant): _____

I hereby certify that I am a person with legal authority to make health care decisions for the Health Plan participant listed above. I have attached the required documentation to establish my status as the Health Plan participant's Personal Representative. I certify that the information on this Personal Representative Form is true, correct, and accurate to the best of my knowledge. I understand that the Health Plans may request information, now or in the future, as it deems necessary to confirm my Personal Representative status.

Signature

Date

Send this completed request form to:
Banyan Administrators, LLC
Managers for the CalCPA ProtectPlus Programs
1215 Manor Drive, Suite 200
Mechanicsburg, PA 17055
Fax – (877) 237-4519
CPAProtectPlus@banyan-llc.com

If you have questions about this form or your right to request to inspect or receive copies of your health information, contact Banyan Administrators, LLC at (877) 480-7923.

For internal use only:

- Approved Notice of extension sent: _____
- Denied Date received: _____ Response Date: _____