AETNA/COVENTRY HIPPA GUIDELINES INFORMATION SHEET

To: All UAW Ford Retirees & Surviving Spouses

On behalf of UAW Region 5 Director Brother Gary Jones, thank you for contacting me concerning your benefits issues. Enclosed is a Member Designated Representative Form, which is required to be filled out by Aetna non-Medicare and Medicare Coventry Health Care Plan. This form is divided into two (2) sections. Please fill out this form, sign, and date it, in order for me to process your benefits claim. Please note that if you are a member, you must fill out Section 2. Please print your name, sign, and date the form. This applies under the Federal Health Insurance Portability and Accountability Act (HIPAA) privacy laws.

To Complete this Form:
Please read all sections carefully!

Section 1: **Designated Representative – General**

This section designates UAW Reps to share in your information because of HIPAA).

This form allows Aetna non-Medicare and Medicare Coventry Health Care Plan and its subcontractors to share information with UAW representatives for the purpose of assisting with or facilitating your health care benefits.

Section 2: **Designated Representative – Mental Health, Substance Abuse, and HIV**

If you check "*YES*," you must also complete the Authorization to Use or Disclose Form.

You have the right not to Authorize the use of this information under the (HIPAA) privacy laws.

So, if you do not want to share this information, please check "*NO*."

Please Read Carefully

I Understand and Agree that:

This area, for example, does not give authorization to your designated representative to exercise authority over any treatment or direct-care decisions to you. We are here only to assist with or facilitate your health benefits.

If you have any questions, please call the number shown on Page 3. I have fully read this form and hereby designate the person listed below as my Designated Representative – UAW/Ford benefits representative and retiree representative to assist in processing your benefits claim.

Because of (HIPAA), please print, sign, and date.

Member Information:

Please print your full name, your health plan, and member ID number, sign and date the form. It is important that you sign and date this form because without a date and your signatures, we will not be able to assist you in solving your benefits problem. This applies under the Federal Health Insurance Portability and Accountability Act (HIPAA) private laws.

If a member is unable to fill out this form, please fill out this area under Member Info, sign, and date it. Fill out an Affidavit or present Power of Attorney.

Personal Representative of Our Member:

If someone other than the member is signing this form (e.g., a Legal Guardian, Power of Attorney, or Personal Representative, Executor, other), please provide your relationship to the member and attach any appropriate documentation of authority. **If you do not sign this document, provide your Power of Attorney or Notarized Affidavit,** we will not be able to share any protected health information with you or any other person. This applies under the Federal Health Insurance Portability and Accountability Act (HIPAA) privacy laws.

Because of (HIPAA), if you do not fill out this form, sign, and date it, we cannot help you.

Designated Representative Information:

The last area on this form is the Designated Representative information, which gives authority to me (or Brother Clint L. Harris) as the designee, for the purpose of assisting with and facilitating your health care benefits. (If you choose not to fill out this form or sign and date it, neither Brother Harris nor I can assist you with your benefits problems). This applies under the Federal Health Insurance Portability and Accountability Act (HIPAA) privacy laws.

Once you have signed, dated, and completed each section of this form, please mail it to the following address:

UAW Region 5
Attn: Vernal Brown, Ford Retiree Benefits Rep.
721 Dunn Road
Hazelwood, MO 63042

You may also fax your form to: (314) 731-2729.

On behalf of Director Jones and me, thank you for filling out this form, so that I can better serve you.

If you have any questions or need assistance with completing this form, please feel free to contact me, Sister Vernal Brown at (314) 731-2800. Once you have completed this form, please mail it back to me in the self-addressed envelope provided for your convenience (*no postage required*).

Thank you.

In solidarity,

Vernal Brown

Vernal Brown
UAW/Ford Retiree Benefits Rep.
UAW Region 5

VB:dt/opeiu494

Enclosures: *(1) HIPPA Form*
(2) Reply Envelope

Coventry Health Care of Missouri
Member Designated Representative Form

SECTION 1: Designated Representative – General
As permitted by the Health Insurance Portability and Accountability Act ("HIPAA"), I hereby designate the person named below to receive my personal health information, including, but not limited to, procedures, and treating providers, from the Coventry Health Care plan ("Coventry") and its subcontractors, for purposes of assisting with or facilitating my health care benefits. I understand that this information may include Protected Health Information and other information protected by HIPAA and other laws.

SECTION 2: Designated Representative – Mental Health, Substance Abuse and HIV
☐ Yes / ☒ No **If yes, you must also complete the Authorization to Use or Disclose Form**

I understand and agree that:

- Coventry and its subcontractors may share my personal health information with the person(s) listed below.
- This authorization does not provide my Designated Representative with any authority over any treatment or direct-care decisions.
- Once released to my Designated Representative, my personal health information may no longer be protected by those laws, and my Designated Representative could share my personal health information with others.
- I am not required to complete this form and my information will not be shared with the Designated Representative unless I sign this form.
- This designation will be effective until the termination of my health plan coverage or until I notify Coventry otherwise.
- I may change or cancel this request at anytime by sending my change in writing to the address below.
- By signing this form, I release Coventry and its subcontractors from any liability of any nature in connection with its release of my personal health information to the person(s) designated below and any use, misuse or secondary release of such information by the person(s) named below.

I have fully read this Form and hereby designate the person listed below as my designated Representative.

Member Name: _____ Phone: ( ) _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Health Plan Name: _____ Member ID Number: _____

Member Signature:* _____ Date: _____

* If someone other than the Member is signing this Form (e.g., a legal guardian), please provide your relationship to the Member and attach any appropriate documentation of authority.

Designated Representative Information:

Designee Name: Vernal Brown Phone: (314) 731-2800

Designee Address: 721 Dunn Road Relationship to Member: UAW-Ford Retiree Benefits Rep.

City, State, Zip Code: Hazelwood, MO 63042

Send this Form to:

Vernal Brown, UAW-Ford Retiree Benefits Rep.
UAW Region 5
721 Dunn Road
Hazelwood, MO 63042

Please keep a copy of this Form for your records