



PERSONAL REPRESENTATIVE APPOINTMENT

Individual Appointing A Personal Representative

Name_____

Address_____

City_____ State____ Zip Code_____

Telephone #_____ E-Mail_____

Delta Dental ID Number_____

Authorized Personal Representative

Print full name of Personal Representative to be appointed:_____

Authorizations Granted In This Appointment

I authorize the release and disclosure of any and all personal health information to my personal representative for the duration of this appointment period.

The personal representative named in this document is authorized to act in my behalf with respect to inquiries regarding my dental claims and benefits during this appointment period. My representative may also act in my behalf with regard to appeals for denied claims.

Appointment Period

This appointment will become effective immediately upon receipt of this fully completed and signed document by Delta Dental of Iowa, and shall remain in effect until such appointment is revoked by me in writing or the end of 365 calendar days from the date it was received by Delta Dental of Iowa.

Signature

I acknowledge that I have had the opportunity to read the contents of this Personal Representative Appointment and I understand that my signature is confirmation of my authorization for Delta Dental of Iowa to use and/or disclose my Protected Health Information to my personal representative for the purposes stated in this form.

Signature of Member Making this Appointment

Date

ACCEPTANCE OF APPOINTMENT

(To be completed by Appointed Personal Representative)

I accept this appointment as Personal Representative for _____
as stated in this document.

Print: Name _____

Address _____

City _____ State ____ Zip Code _____

Telephone: _____

Where to send this Personal Representative Appointment

Mail to : Delta Dental of Iowa
 PO Box 9000
 Johnston IA 50131-4817

Or Fax to: (888) 264-1440

04/23/10