

**Trustmark Insurance Company/ Trustmark Life Insurance Company**  
(Referred to as Trustmark)

**APPOINTMENT OF PERSONAL REPRESENTATIVE**

**I. MEMBER DATA**

Personal Representative Requested For: \_\_\_\_\_

Relationship to Member:    \_\_\_ Self        \_\_\_ Dependent

Member's Name: \_\_\_\_\_

Member's Social Security: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Member's Address: \_\_\_\_\_

Member's City/State/Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**II. NATURE OF REQUEST**

A. An individual has a right to appoint a Personal Representative to act on their behalf to receive Protected Health Information (PHI) related to claim and health information.

B. Please check the appropriate box that apply to your request(s).

I appoint the individual \_\_\_\_\_ to act as my  
(name of appointed personal representative)  
Personal Representative, to access, amend, and copy my PHI under all rights of the HIPAA Privacy Rules effective \_\_\_\_\_. This appointment shall be effective until I notify Trustmark in writing, to end the appointment.

I authorize the individual \_\_\_\_\_ to discuss, on my behalf,  
(name of authorized person)  
my PHI, for the below condition or claim:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**III. PERSONAL REPRESENTATIVE INFORMATION**

Name of Personal Representative (please print): \_\_\_\_\_

Relationship To Insured: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**Requestor's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Requestor's Name (please print):** \_\_\_\_\_

**Mail Completed Form To:**

Privacy Officer  
HIPAA Compliance Department  
Trustmark Insurance Company  
P.O. Box 7961  
Lake Forest, IL 60045-7961