GlobeHopper℠ Senior

Designation of a Authorized Representative Statement

Please print clearly, complete all sections.					
INSURED NAME: LAST	FIRST	MIDDLE INITIAL			
INSURED ADDRESS: STREET ADDRESS	CITY	STATE	ZIP	COUNTRY	
PHONE NUMBER:	**DATE OF BIRTH** (MM/DD/YYYY)**:**	**EMAIL ADDRESS:**			
INSURED ID NUMBER:		**EFFECTIVE DATE** (MM/DD/YYYY)**:**			
NAME OF PRIMARY CARE PHYSICIAN:		**PHYSICIAN PHONE NUMBER:**			

NAME OF AUTHORIZED REPRESENTATIVE: LAST	FIRST	MIDDLE INITIAL			
RELATIONSHIP TO INSURED MEMBER:					
REPRESENTATIVE ADDRESS: STREET ADDRESS	CITY	STATE	ZIP	COUNTRY	
PHONE NUMBER:	**DATE OF BIRTH** (MM/DD/YYYY)**:**	**EMAIL ADDRESS:**			

I affirm that I am the above named Insured and do hereby appoint the above named individual to act on my behalf and as my representative in connection with pursuing a claim, an appeal of a denied claim, or asserted rights under the above insurance contract. I authorize this individual to make any request for benefits, complete and submit claim forms, present or to elicit evidence, obtain information regarding claim and appeal decisions, and to receive any notice in connection with my claims and/or appeal, wholly in my stead. I understand that protected health information and nonpublic personal information related to my claim may be disclosed to the representative appointed above. This designation is subject to revocation at any time by the insured except to the extend IMG and/or its affiliates have taken action in reliance on the designation before they knew of the revocation.

Member's Signature: _____

Member's Printed Name: _____ **Date:** _____

I hereby accept the above appointment. I certify that I am not disqualified, suspended, or prohibited from serving as the insured's representative and I recognize my appointment is subject to periodic verification and compliance with laws applicable to the insured.

Representative's Signature: _____

Representative's Printed Name: _____ **Date:** _____

Please send completed forms to the below address or email. If you have any questions regarding this form, please contact our Customer Care team:

Address: International Medical Group,
Inc. Claims, P.O. Box 240429, Apple
Valley, MN 55124 USA,
Call: +1.800.628.4664 or outside U.S.
+1.317.655.4500;
Fax: 1-317-655-4505