



## STATEMENT OF REPRESENTATIVE

I \_\_\_\_\_, appoint \_\_\_\_\_  
(Member's name) (Representative's name)

to act as my representative for matters related to my enrollment and membership in UCare health plans as described below. This person will be my agent, and I authorize him/her to act for me and in my name to the extent stated in this document in the same way that I could act if I were present. I grant my representative the ability to do the things below by checking "Yes." Checking "No" means that my representative is not authorized to make those decisions. For areas marked "Yes," my representative will have the power stated beginning on the day that I sign this document. He/she will continue to have these powers if I become unable to make these decisions on my own.

I understand that if my representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my confidential information received by my representative, as designated below, may be further disclosed by my representative without my authorization, and may no longer be protected by privacy laws.

Yes     No

1. I allow my representative to enroll me in an appropriate UCare plan to pay any applicable insurance premiums; to select from the benefit options under such policies; and to pursue all insurance claims on my behalf.

Yes     No

2. I allow my representative to make decisions regarding my membership in UCare health plans, including changing my primary care clinic, discussing claims and insurance-related issues, and receiving from or discussing confidential health information about me and my health status with UCare representatives. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral, developmental, or mental health services and treatment for alcohol or drug abuse.

(continued)

Yes     No    3. I instruct UCare to send all UCare health plan member correspondence to my representative at his/her mailing address, shown below. I want my representative to receive confidential information about me, such as claims information. I understand that if I check the "Yes" box, my representative will receive ALL member materials, updates, premium notices, claims information, and other mail on my behalf. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral, developmental, or mental health services and treatment for alcohol or drug abuse.

Yes     No    4. I allow my representative to make decisions, in my best interest, regarding disenrollment from UCare health plans.

Yes     No    5. Other (please explain): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Relationship to Representative.** My representative is my \_\_\_\_\_  
(spouse, parent, child, friend, etc.)

**I understand that by signing below I am giving another person the legal power to make certain decisions for me on my behalf. I also understand that UCare will rely on this authorization to release private information to my representative and make changes to my member status. I understand that I may revoke these authorizations at any time by telling UCare in writing that I wish to do so. However, I understand that my revocation of this authorization will not affect any action UCare has taken, or any information that UCare has already released, based upon this authorization before UCare actually received my request to revoke it.**

I understand that UCare does not condition treatment, payment, enrollment or eligibility for benefits on the execution of this form.

(continued)

To become effective, this document must be completed and signed by me and accepted below by my representative. This authorization expires one year from date of signature if my representative is performing the following activities on my behalf: appeal, denial, coverage determination or organization determination; a decision made about an authorization or payment for health care.

Signature of party seeking representation: \_\_\_\_\_

Date Signed: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

UCare Member #: \_\_\_\_\_

If I cannot physically sign my name on this form. I can ask someone to sign for me.

Printed name of person I ask to sign for me: \_\_\_\_\_

Signature of person I ask to sign for me: \_\_\_\_\_

**ACCEPTANCE BY REPRESENTATIVE:** (to be completed by the representative)

The individual below, who has been designated as a representative in this document, accepts appointment as the named representative, subject to the terms and conditions of this document.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

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

\_\_\_\_\_

Phone #: \_\_\_\_\_

Return completed form to: UCare PO Box 52 Minneapolis, MN 55440-0052  
Fax: 612-676-6501 | Email: [CLSScanReqInq@ucare.org](mailto:CLSScanReqInq@ucare.org)

**Toll free 1-800-203-7225, TTY 1-800-688-2534**

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጎምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤတွဲရက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរសព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သျှ်ဟ်သးဘၣ်တက့ၢ်. ဝဲနမ့ၢ်လိၣ်ဘၣ်တၢ်မၤစၢၤကလိလၢတၢ်ကကျိးထံဝဲဒၣ်လံာ် တီလံာ်မိတခါအံၤန့ၣ်, ကိးဘၣ် လိတဲစိနီၣ်ဂံၢ်လၢထးအံၤန့ၣ်တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າທາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ພຣີ, ຈົ່ງ ໂທໂປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

## Civil Rights Notice

**Discrimination is against the law.** UCare does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

**Auxiliary Aids and Services.** UCare provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner, to ensure an equal opportunity to participate in our health care programs. **Contact** UCare at 612-676-3200 (voice) or 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

**Language Assistance Services.** UCare provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact** UCare at 612-676-3200 (voice) or 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

## Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UCare. You may contact any of the following four agencies directly to file a discrimination complaint.

### U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion (in some cases)

Contact the **OCR** directly to file a complaint:

U.S. Department of Health and Human Services'  
Office for Civil Rights  
200 Independence Avenue SW  
Room 515F  
HHH Building  
Washington, DC 20201  
Customer Response Center: Toll-free: 800-368-1019  
TDD 800-537-7697  
Email: [ocrmail@hhs.gov](mailto:ocrmail@hhs.gov)

### **Minnesota Department of Human Rights (MDHR)**

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights  
540 Fairview Avenue North  
Suite 201  
St. Paul, MN 55104  
651-539-1100 (voice)  
800-657-3704 (toll free)  
711 or 800-627-3529 (MN Relay)  
651-296-9042 (Fax)  
[Info.MDHR@state.mn.us](mailto:Info.MDHR@state.mn.us) (Email)

### **Minnesota Department of Human Services (DHS)**

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. After we get your complaint, we will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal the outcome if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator  
Minnesota Department of Human Services  
Equal Opportunity and Access Division  
P.O. Box 64997  
St. Paul, MN 55164-0997  
651-431-3040 (voice) or use your preferred relay service

### **UCare Complaint Notice**

You have the right to file a complaint with UCare if you believe you have been discriminated against in our health care programs because of any of the following:

- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information
- disability (including mental or physical impairment)
- marital status
- age
- sex (including sex stereotypes and gender identity)
- sexual orientation
- national origin
- race
- color
- religion
- creed
- public assistance status
- political belief

You can file a complaint and ask for help in filing a complaint in person or by mail, phone, fax, or email at:

#### **UCare**

Attn: Appeals and Grievances  
PO Box 52  
Minneapolis, MN 55440-0052  
Toll free: 1-800-203-7225  
TTY: 1-800-688-2534  
Fax: 612-884-2021  
Email: [cag@ucare.org](mailto:cag@ucare.org)