ASPIRUS HEALTH PLAN

STATEMENT OF REPRESENTATIVE

I _____, appoint _____
(**Member's name**) (**Representative's name**)

to act as my representative for matters related to my enrollment and membership Aspirus Health Plan 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 Aspirus Health 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 Aspirus Health Plan, 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 Aspirus Health Plan 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 or mental health services and treatment for alcohol or drug abuse.

(continued)

❑ Yes ❑ No

3. I instruct Aspirus Health Plan to send all 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 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 Aspirus Health Plan.

❑ 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 Aspirus Health Plan 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 Aspirus Health Plan in writing that I wish to do so. However, I understand that my revocation of this authorization will not affect any action Aspirus Health Plan has taken, or any information that Aspirus Health Plan has already released, based upon this authorization before Aspirus Health Plan actually received my request to revoke it.

I understand that Aspirus Health Plan 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: _____

_____

_____

Aspirus Health Plan 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: Aspirus Health Plan PO Box 51 Minneapolis, MN 55440
Fax: 715-787-7307 | Email: CLSScanReqIncMA@aspirushealthplan.com

Notice of Nondiscrimination

Aspirus Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aspirus Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

We provide aids and services at no charge to people with disabilities to communicate effectively with us, such as TTY line, or written information in other formats, such as large print.

If you need these services, contact us at **715.631.7411 (voice)** or toll free at **1.855.931.4850 (voice)**, **715.631.7413 (TTY)**, or **1.855.931.4852 (TTY)**.

We provide language services at no charge to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services, contact us at the **number on the back of your membership card** or **715.631.7411** or toll free at **1.855.931.4850 (voice)**; **715.631.7413** or toll free at **1.855.931.4852 (TTY)**.

If you believe that Aspirus Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file an oral or written grievance.

Oral grievance

If you are a current Aspirus Health Plan member, please call the number on the back of your membership card. Otherwise please call **715.631.7411** or toll free at **1.855.931.4850 (voice)**; **715.631.7413** or toll free at **1.855.931.4852 (TTY)**. You can also use these numbers if you need assistance filing a grievance.

Written grievance
Mailing Address
Attn: Appeals and Grievances
Aspirus Health Plan
PO Box 51
Minneapolis, MN 55440
Email: cagMA@aspirushealthplan.com
Fax: 715.631.7439

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200
Independence Avenue SW
Room 509F, HHH Building Washington, D.C.
20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 715.631.7411/1.855.931.4850（TTY：715.631.7413/1.855.931.4852）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 715.631.7411/1.855.931.4850 (телетайп: 715.631.7413/1.855.931.4852).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 715.631.7411/1.855.931.4850 (**መስማት ለተሳናቸው**: 715.631.7413/1.855.931.4852).

ဟ်သူဉ်ဟ်သး–နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤနှ်၊ ကျိာ်အတ်မၤစၢၤလ၊ တလၫ်ဘူဉ်လၫ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ.
ကိး 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយា ភាសារ៉ែខ្មរ, រសវាជំនួយរ៉ែផ្នកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរ៉ើអ្នក។ ចូរ ទូរស័ព្ទ 715.631.7411/ 1.855.931.4850 (TTY: 715.631.7413/ 1.855.931.4852)។

ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 715.631.7411/1.855.931.4850 (رقم هاتف الصم والبكم:1.855.931.4852/ 715.631.7413).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 715.631.7411/1.855.931.4850 (ATS : 715.631.7413/1.855.931.4852).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/ 1.855.931.4852) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).