



**AUTHORIZED REPRESENTATIVE APPOINTMENT FORM**

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_,  
(member name) (name)

whose address is \_\_\_\_\_  
street city state zip code

and telephone number is (\_\_\_\_\_) \_\_\_\_\_, to communicate with US Able Administrators

on my behalf regarding the \_\_\_\_\_  
(service, supply, prescription drug, equipment or treatment)

performed or to be performed on \_\_\_\_\_, 20\_\_ by \_\_\_\_\_.  
(physician or health care provider)

I understand and agree that my Authorized Representative shall have the authority to represent me in all matters concerning my health claim.

I understand and agree that US Able Administrators shall send correspondence, notices and benefit determinations in connection with my health claims to the Authorized Representative, upon their request for such information. I further understand and agree that it will take US Able Administrators a reasonable period, approximately thirty (30) days, to notify all its personnel about the termination of this appointment of the Authorized Representative and it is possible that the Company may communicate information about me to the Authorized Representative during this notification period.

This authorization shall remain valid until I notify US Able Administrators in writing to terminate it or until this health claim has been resolved, whichever occurs first.

\_\_\_\_\_  
Member Signature

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

\_\_\_\_\_  
Member Name (Print)

\_\_\_\_\_  
US Able Administrators ID Number