



Banner
Plan Administration

P.O. Box 16846
Mesa, AZ 85211-6846
(480)684-7000 or (888)227-3688
Fax: (480)684-7201

<<DATE>>

«Last_Name»
«Address_Line_1»
«City»

RE: Assignment of Authorized Representative
Claim # «Title»

I, _____
(Print Your Name)

hereby authorize _____ to act on my
(Print name of Authorized Representative)

behalf regarding Banner Plan Administration (BPA)/Short Term Disability (STD),
Family Medical Leave (FML), Long Term Disability (LTD) or Workers' Compensation
(WC) (collectively referred to as "BPA Program Benefits").

I hereby authorize my representative to receive any and all correspondence requiring follow up on my behalf. My assigned representative may communicate via phone or written correspondence on my behalf when involving BPA Program Benefits. This also includes requesting on my behalf information associated with preparing and submitting a formal appeal if BPA Program Benefits are denied.

This authorization will remain in effect until I formally notify BPA in writing that it is either rescinded or a new representative is named.

Please sign and return this document to BPA either via mail or fax at the address or fax number listed above.

Claimant Signature (Required) Date of Birth Date

Accepted: _____
Authorized Representative's Signature (Required)

(Dis Rep Initials)