DESIGNATION OF AUTHORIZED REPRESENTATIVE

I, ***(insert claimant name)***, do hereby appoint **(*insert authorized representative*)** (hereinafter "my Authorized Representative") to act on my behalf in pursuing benefit or claim status. My Authorized Representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of claims, any requests for documents relating to claims, and any appeal of an adverse determination of claims.

I understand that in the absence of a contrary direction from me, INTEGRA Administrative Group, Inc. (the "Plan") will direct all information and notices regarding claims to which I otherwise am entitled, including benefit determinations, to my Authorized Representative **only.**

I am aware that the Standards for Privacy of Individually Identifiable Health Information set forth by the U.S. Department of Health and Human Services (the "Privacy Standards"), govern access to medical information. I understand that in connection with the performance of his/her duties hereunder, my Authorized Representative may receive my Protected Health Information, as defined in the Privacy Standards, relating to claims. I hereby consent to any disclosure of my Protected Health Information to my Authorized Representative.

Date: _____ _____

Signature of Claimant

ACKNOWLEDGEMENT

I, **(*insert authorized representative*),** have read the above Designation of Authorized Representative and I hereby accept this designation and agree to act as Authorized Representative for **(*insert name of claimant*)** with respect to benefits and claims.

Date:_____ _____

Signature of Representative

110 South Shipley Street
Seaford DE 19973
800-959-3518 or 302-629-3518