Lockheed Martin Corporation
Request for a Personal Representative

LOCKHEED MARTIN

This form will allow me to designate another person as my personal representative ("Representative"). I understand that by completing and signing this form, I authorize the Health Plan to treat my Representative as myself, and that he or she will receive all Protected Health Information correspondence instead of me. I understand that Protected Health Information will continue to be addressed to me, but will be sent to the Representative at the address specified below. I understand that I will not receive duplicate information and that the Health Plan must approve this Request for a Personal Representative before it will become effective.

Note: The Representative will have access to all of your Member/Participant information and will be able to exercise your rights, including rights to access or amend your Protected Health Information. You will not be able to access or amend your Protected Health Information. Only the person you designate as your Representative will be able to exercise those rights on your behalf.

SECTION 1: Identification of Member/Participant and Type of Coverage (Please complete all applicable items):

A. Member Information

Last Name		First Name	Middle Initial
Member I.D. Number	Social Security Number	Birthdate (MM/DD/YY)	Daytime Telephone Number (include area code)
Street Address			City, State and Zip Code

B. Employee information (if different than Member)

Last Name		First Name	Middle Initial
I.D. Number on Member Card	Social Security Number	Birthdate (MM/DD/YY)	Daytime Telephone Number (include area code)
Street Address			City, State and Zip Code

C. Type of coverage to which this form applies (check all that apply):

☐ Health ☐ Long Term Care ☐ EAP

(specify applicable health benefits below):

- ☐ Medical
- ☐ Dental
- ☐ Vision
- ☐ Mental Health
- ☐ Prescription Drug
- ☐ Health Care Spending Account
- ☐ Other (please specify):_____

Identification of Personal Representative

Name of Personal Representative: _____

Relationship to Member: _____

Address where communications about this Member/Participant should be sent:

SECTION 2: VERIFICATION QUESTIONS (In this section "You" and Your" refer to the Personal Representative.)
The answers you provide will be used to verify your identity if you call for private health Information about the Member/Participant. You must answer these questions:

What is your mother's date of birth: (answer in the following 8-digit format: 11231949 for November 23, 1949)

___ ___ ___ ___ ___ ___ ___ ___

Last 4 digits of your favorite credit card: ___ ___ ___ ___

Please DO NOT provide anyone else with the answers to these questions. When you call, the Health Plan will ask you to provide the information you gave us above, so we can verify your identity. Note that we ask these questions, because the answers should be easy for

you to remember. The Health Plan does not know your mother's date of birth or credit card number. Please keep a copy of this form for reference.

- Certain information (e.g. plan enrollment) is based on payroll records and cannot be forwarded to an alternate location.
- I understand that if the information on this form is not complete, the Health Plan will return the form to me and can not recognize any individual as a Personal Representative until it has received all information and complete verification of information.
- If any enrollment information such as Social Security Number (SSN), member ID or date of birth is changed, another form will need to be completed at that time.
- If either the Member/Participant changes health care benefits coverage within the Health Plan, another form will need to be completed at that time.
- You may end or change this Request for Representative by notifying the Health Plan in writing.

Any previous request to send information to an alternate address will be disregarded. All future correspondence will be sent to the personal representative identified above.

SECTION 3: SIGNATURE AND NOTARIZATION

To safeguard your privacy and help make sure no one else is requesting access to your PHI, this request must be notarized. (Notary services can often be provided free of charge at a bank or financial institution where you have an account.)

I have read and understand the above information: Date:_____

Signature of Individual who is to be represented or, if applicable, the Parent/Guardian or Personal Representative:
(sign here)_____
Print Name:_____

Address: _____

Relationship if signed by other than Individual:_____

Note that, if not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete.

If this request is made by a Parent/Guardian, complete the following: Member/Participant is a minor ___years of age. If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

Date: _____ Notary Public Signature: _____

My Commission expires on: _____

Please forward this request to:

HIPAA Privacy Office
Lockheed Martin Corporation
6801 Rockledge Drive, CCT-115
Bethesda, MD 20817

For Internal Use:	
Date Received: _____	Date Copy Sent to Requesting Party: _____
Action Taken: _____	Copy of Request Also Sent to: _____

Upon written request, the person signing this form will receive a copy of this signed Request for a Personal Representative.