EQUITY-LEAGUE BENEFIT FUNDS
PENSION, HEALTH & 401(K)

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Equity-League Health Trust Fund (the "Plan") *Appointment of Personal Representative Form*[1]

I, _____ [Name of Participant or Beneficiary]

Mailing address: _____

Phone: (_____)_____

hereby designate: _____ [Name of Personal Representative]

Mailing address: _____

Phone: (_____)_____

Relationship to Participant or Beneficiary _____ to act on my behalf or

on behalf of: _____ [Name of Dependent]

I authorize my Personal Representative to act for me [and for my covered spouse, domestic partner or dependent, if named above,] in receiving any information that is (or would be) provided to me as a participant/beneficiary of the Plan, including but not limited to, any information that relates to my claim for coverage or benefits under the Plan and any individual rights that I have regarding my protected health information under HIPAA.

I understand that this designation is subject to approval by the Plan. I also understand that, once approved, this designation will remain in effect unless I revoke it. I understand that I have the right to revoke this designation at any time by submitting a signed statement to that effect to the Fund Office.

I certify that I have reviewed the Plan's Policy for Recognition of Personal Representative. This form must be notarized or include a photocopy of your union membership identification card or some other form of identification (i.e., driver's license or passport).

_____ _____

Participant/Beneficiary's Signature Date

[1] This form will also satisfy the Plan's obligation under ERISA's claims and appeals regulation to have a process for recognizing "authorized" representatives in dealing with specific claims.