RESET

Braven HEALTH

Request to Terminate an Appointed Legal or Limited Personal Representative

Read instructions on p. 2 before completing this form. ALL FIELDS MUST BE COMPLETED.

A separate form is required for each member on the policy, as applicable. Please print all information legibly, except where signature is required.

To request the termination of a Legal or Limited personal representative that was created for you, please complete the information below, sign in the space provided and return to: Braven Health, Attn: HIPAA Team, P.O. Box 1458, Newark, New Jersey 07101-1458 or via fax at 973-274-2358.

SECTION A: MEMBER'S INFORMATION

Name (☐ *Subscriber* ☐ *Dependent*): _____

Subscriber Identification #: _____

Date of Birth: _____ / _____ / _____ Telephone #: _____ - _____ - _____
MM DD YYYY

Address: (on file) _____

City: _____ State: _____ ZIP: _____

I, _____, hereby wish to terminate the legal or limited personal
(member name – please print)

representation of_____ , my legal or limited personal representative.
(Legal or limited personal representative name – please print)

I understand this request applies to communications from Braven Health and its Business Associates about my private information, but will **not** terminate contract communications from Braven Health (and its Business Associates) to the subscriber of my coverage.

Effective Date for Termination of Personal Representation: _____ / _____ / _____
MM DD YYYY

IMPORTANT NOTE: The above date **cannot** be a date prior to the completion of this form. If no date is provided, or a date is selected that is prior to the date this form is received by Braven Health, Braven Health will consider the requested effective date to be the date Braven Health processes this form. In addition, notwithstanding the date provided above, the legal or limited personal representation will remain in effect until Braven Health has approved, fully processed and implemented this request, which may not occur until after the requested effective date.

SECTION B: APPOINTED LEGAL OR LIMITED PERSONAL REPRESENTATIVE TO BE TERMINATED
(required for privacy verification purposes)

Name (Last, First, MI): _____

Last 4 Digits of Social Security #: _____ Date of Birth: _____ / _____ / _____
MM DD YYYY

Address: _____

City: _____ State: _____ ZIP: _____

Telephone #: _____ - _____ - _____ Relationship to the member: _____

Reason for termination: _____

_____

NOTE: If the representative is court-ordered or is your legal personal representative through another legal designation (examples: power of attorney, living will, executor or administrator of probate estate), you must include an explanation (see last line above) or attach/include a copy of the official document(s) that terminates or nullifies his/her legal personal representation, if not already provided. If you are a documented legal personal representative, you may make this Request and sign this form below on behalf of the member.

☐ Check here if you want your response to this request sent via email. Email address: _____

Signature of ☐ Member ☐ Requestor: _____ Date: _____ / _____ / _____
(check whether member or other requestor) MM DD YYYY

Printed Name: _____

INSTRUCTIONS

REQUEST TO TERMINATE AN APPOINTED LEGAL OR LIMITED PERSONAL REPRESENTATIVE

General Instructions: All fields are required to be completed unless otherwise specified.

This form must be completed when a member wishes to terminate an appointed legal or limited personal representative. All required legal documents will undergo a validation process by Braven Health. If you are a documented legal or limited personal representative, you may make this request and sign the form on the bottm section on behalf of the member.

NOTE: A separate form and documentation is required for each member on the coverage, as applicable, even if terminating the same legal or limited personal representative.

Section A: Member Information

This section requests information related to the member requesting the termination of their legal or limited personal representative. Since this information is used for verification purposes, the information included in this section should match the most current information on file for the member/subscriber. Please be aware that this form may be denied if the information on the form does not match the information in our systems.

Section B: Appointed Legal or Limited Presonal Representative to be Terminated

The requested information in this section will be used by Braven Health for verification purposes.

1. *Name of legal or limited personal representative.* Enter the full name for the legal or limited personal representative that you are requesting to be terminated.

2. *Date of Birth.* Enter the legal or limited personal representative's month, day and year of birth (MM/DD/YYYY).

3. *Reason for termination.* Provide the reason for the request to terminate the legal or limited personal representative. If the personal representative is court-ordered or is the member's legal personal representative through another legal designation, such as a power of attorney or guardianship order, the requestor of the termination must include an explanation and attach a copy of the official document(s) that terminates or nullifies the legal representation.

NOTE: All correspondence that would normally be sent to your legal or limited personal representative, will now be sent to the member's address. Correspondence may include checks, EOBs and bills, as well as other items. Nevertheless, all correspondence, including checks, will still be issued under the member's / subscriber's name.

A Qualified Domestic Relationship Order (QDRO) is required if you wish to have all correspondence, including checks, issued in your name.

Mail this form to:

Braven Health
Attn: HIPAA Team
PO Box 1458
Newark, NJ 07101-1458

Or Fax to: (973)274-2358