STATEMENT OF REPRESENTATIVE

I _____, appoint _____
(**Member's name**) (**Representative's name**)

to act as my representative for matters related to my enrollment and membership in UCare Connect + Medicare (HMO SNP), as described below. This person will be my agent, and I authorize him/her to act for me and in my name to the extent stated in this document in the same way that I could act if I were present. I grant my representative the power and authority to do the things below by checking "Yes." Checking "No" means that my representative is not authorized to make those decisions. For areas marked "Yes," my representative will have the power stated beginning on the day that I sign this document. He/she will continue to have these powers if I become incompetent or incapacitated or otherwise unable to make these decisions on my own.

I understand that if my representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my confidential information received by my representative, as designated below, may no longer be protected by privacy laws, and may be further disclosed by my representative without my authorization.

❑ Yes ❑ No

1. I allow my representative to enroll me in an appropriate UCare plan, including UCare Connect + Medicare, or Medicare supplement insurance; to pay all insurance premiums; to select from the benefit options under such policies; and to pursue all insurance claims on my behalf.

❑ Yes ❑ No

2. I allow my representative to make decisions regarding my membership in UCare Connect + Medicare, including changing my primary care clinic, discussing claims and insurance-related issues, and receiving from or discussing confidential health information about me and my health status with UCare Connect + Medicare representatives. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services and treatment for alcohol or drug abuse.

(continued)

❑ Yes ❑ No

3. I instruct UCare to send all UCare Connect + Medicare member correspondence to my representative at his/her mailing address, shown below. I want my representative to receive confidential information about me, such as claims information. I understand that if I check the "Yes" box, my representative will receive ALL member materials, updates, premium notices, claims information, and other mail on my behalf. I understand that I will NOT receive extra copies from UCare. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services and treatment for alcohol or drug abuse.

❑ Yes ❑ No

4. I allow my representative to make decisions, in my best interest, regarding disenrollment from UCare Connect + Medicare.

❑ Yes ❑ No

5. Other (please explain): _____
_____
_____

Relationship to Representative. My representative is my _____
(spouse, parent, child, friend, etc.)

I understand that by signing below I am giving another person the legal power to make certain decisions for me on my behalf. I also understand that UCare will rely on this authorization to release private information to my representative and make changes to my member status. I understand that I may revoke these authorizations at any time by telling UCare in writing that I wish to do so. However, I understand that my revocation of this authorization will not affect any action UCare has taken, or any information that UCare has already released, based upon this authorization before UCare actually received my request to revoke it.

I understand that UCare does not condition treatment, payment, enrollment or eligibility for benefits on the execution of this form.

(continued)

To become effective, this document must be completed and signed by me and accepted by my representative. This authorization expires one year from date of signature if my representative is performing the following activities on my behalf: appeal, denial, coverage determination or organization determination.

Signature of party seeking representation: _____

Date Signed: _____ Phone #: _____

Address: _____ Date of Birth: _____

_____

_____ Medicare #: _____

UCare Member #: _____

If I cannot physically sign my name on this form. I can ask someone to sign for me.

Printed name of person I ask to sign for me: _____

Signature of person I ask to sign for me: _____

ACCEPTANCE BY REPRESENTATIVE: (to be completed by the representative)

The undersigned, who has been designated as a representative in this document, accepts appointment as the named representative, subject to the terms and conditions of this document.

Printed Name: _____

Signature: _____

Address: _____

_____

_____

Phone #: _____

UCare Connect + Medicare (HMO SNP) is a health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in UCare Connect + Medicare depends on contract renewal.

1-800-203-7225

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တက့်. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဇဉ်လံာ် တီလံာ်မီတခါအံၤန့ဉ်, ကိးဘဉ်လီတဲစိနီ်ဂ်ံလၢထးအံၤန့ဉ်တက့်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ, ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

Civil Rights Notice

Discrimination is against the law. UCare does not discriminate on the basis of any of the following:

- Race
- Color
- National Origin
- Creed
- Religion
- Sexual Orientation
- Public Assistance Status
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)
- Marital Status
- Political Beliefs
- Medical Condition
- Health Status
- Receipt of Health Care Services
- Claims Experience
- Medical History
- Genetic Information

Auxiliary Aids and Services. UCare provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner, to ensure an equal opportunity to participate in our health care programs. **Contact** UCare at 612-676-6500 (voice) or 1-866-457-7144 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

Language Assistance Services. UCare provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact** UCare at 612-676-6500 (voice) or 1-866-457-7144 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UCare. You may contact any of the following four agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- Race
- Color
- National Origin
- Age
- Disability
- Sex (including sex stereotypes and gender identity)

Contact the OCR directly to file a complaint:

Director
U.S. Department of Health and Human Services' Office for Civil Rights
200 Independence Avenue SW
Room 509F
HHH Building
Washington, DC 20201
800-368-1019 (Voice)
800-537-7697 (TDD)
Complaint Portal – *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- Race
- Color
- National Origin
- Religion
- Creed
- Sex
- Sexual Orientation
- Marital Status
- Public Assistance Status
- Disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
Freeman Building, 625 North Robert Street
St. Paul, MN 55155
651-539-1100 (voice)
800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (Fax)
Info.MDHR@state.mn.us (Email)

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- Race
- Color
- National Origin
- Creed
- Religion
- Sexual Orientation
- Public Assistance Status
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)
- Marital Status
- Political Beliefs
- Medical Condition
- Health Status
- Receipt of Health Care Services
- Claims Experience
- Medical History
- Genetic Information

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. After we get your complaint, we will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have a right to appeal the outcome if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome period. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administration actions.

Contact **DHS** directly to file a discrimination complaint:

ATTN: Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

UCare Complaint Notice

You have the right to file a complaint with UCare if you believe you have been discriminated against in our health care programs because of any of the following:

- Race
- Color
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- Creed
- Religion
- Sexual Orientation
- Public Assistance Status
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)
- Marital Status
- Political Beliefs
- Medical Condition
- Health Status
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- Claims Experience
- Medical History
- Genetic Information

Phone: 612-676-3200
1-800-203-7225 toll free
TTY: 612-676-6810 or
1-800-688-2534 toll free
Email: cag@ucare.org
Fax: 612-884-2021

Mailing address
UCare
Attn: Appeals and Grievances
PO Box 52
Minneapolis, MN 55440-0052