SEAFARERS HEALTH AND BENEFITS PLAN

POWER OF ATTORNEY FOR HEALTH CARE CLAIMS

I, _____, of _____

(insert your full name) *(insert your address)*

do hereby constitute and appoint my _____, _____

(Spouse, Parent, Child or other) *(insert full name of person appointed)*

of _____ to be my true, sufficient and lawful attorney

(insert address)

to act for me in my name, place and stead, and on my behalf, and for my use and benefit.

I hereby authorize and empower my attorney in fact, sole and absolute discretion:

1. **to submit my medical claims to the Seafarers Health and Benefits Plan for payment;**
2. **to have unrestricted access to all Plan information and correspondence concerning the payment status of any of my medical claims; and**
3. **to act on my behalf and perform any function related to the claims processing procedure.**

This instrument shall be construed and interpreted as a special power of attorney limited in scope to the authority to act on my behalf for the above-stated purposes.

The rights, powers and authority of said attorney in fact granted in this instrument shall commence and be in full force and effect on _____, and such rights, powers and authority shall remain in full force

(Effective Date)

and effect, thereafter until I, _____, give notice in writing that such power is terminated.

(Insert your full name)

_____ **Dated: _____ Last 4 digits of SSN _____**

(Signature of Principal)

THIS FORM MUST BE NOTARIZED.

State of _____ County of _____

On , _____, before me personally came, _____, to me

(Date) *(Principal)*

Known to be the person described herein and who executed the foregoing instrument and acknowledged that he/she had executed the same.

Notary Public:_____

My Commission Expires: _____