Jackson Care Connect™
Part of the CareOregon Family

Appointment of representative

I authorize the person named below to be my Representative, to act on my behalf to make all decisions related to my Jackson Care Connect coverage, as if I were doing so myself. My Representative may receive my health information from and disclose such information to Jackson Care Connect and its affiliates ("Plan") if necessary to make decisions related to my Plan coverage.

Member information

Name: _____

Date of birth (or member ID): _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone#: _____ Email: _____

Representative information

Name: _____

Relationship to member: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone#: _____ Email: _____

I am appointing this Representative to act on my behalf regarding any matter related to my insurance coverage and benefits provided by my Plan. This includes acting on my behalf to share my health information with the Plan and/or to request my health information from the Plan, as it relates to enrollment, premium payments, benefits, claims, address changes, provider changes, requests for special communications, and/or assistance with complaints, grievances or appeals. I understand that information released to my Representative as permitted by this form may relate to drug/alcohol treatment, mental health, and HIV information. I understand that I have a right to revoke this appointment in writing at any time and to send my written revocation to the Plan at the address listed below.

This appointment will remain in effect indefinitely unless I specify an earlier expiration date here: _____

Signature: _____

Date: _____

Printed name: _____

If anyone signs for the member, please provide a copy of Power of Attorney or other legal document giving that permission.

Representative Signature: _____

Fax completed form to: 503-416-3723

OR

Mail to: Customer Service Jackson Care Connect
315 SW Fifth Ave
Portland OR 97204