SHBP POWER OF ATTORNEY
HEALTH CARE CLAIMS

I, _____ (Insert your full name) of _____

_____ (Address), do hereby constitute and appoint

my_____ (Spouse, Parent, Child or other), _____

(Insert the full name of the person appointed) of _____

_____(Address) to be my true, sufficient and lawful attorney 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 _____ (Effective Date), and such

rights, powers and authority shall remain in full force and effect, thereafter until I, _____(Insert your full name), give notice in writing that such power is terminated.

Dated: _____ _____
(Signature of Principal)

SS#_____-_____-_____

THIS FORM MUST BE NOTARIZED

State of _____

County of _____

On _____ (Date) before me personally came _____ (Principal), to me 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: _____

Seal