

**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 \_\_\_\_\_,  
*(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: \_\_\_\_\_