DELTA DENTAL®

Delta Dental of New Mexico

Appointment of Authorized Representative

Date _____

Name _____

Subscriber ID Number _____

Appointment/Recognition of Authorized Representative

I hereby appoint _____ to act on behalf of _____
(Name of Representative) (Name of Patient, Employee, Covered Spouse, or Dependent)

I authorize my representative to receive any and all information that is provided to me, and to act for me and for my covered spouse or dependent, if named above as the patient, in providing any information to Delta Dental of New Mexico that relates to any claim for coverage or benefits under the plan.

I acknowledge that appointment of an authorized representative is:

❑ Permanent ❑ Temporary

If the appointment is temporary, please indicate the date through which the above-named representative may act as your authorized representative: _____

Signature of Individual and Individual's Representative

_____ _____
Subscriber Signature Date

_____ _____
Authorized Representative Signature Date