

**CONSTRUCTION  
INDUSTRY LABORERS**

**FRINGE BENEFIT FUNDS**

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Managed for the Trustees by  
Wilson-McShane Corporation

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## Appointment of Personal Representative

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I, \_\_\_\_\_ [Name of Participant or Beneficiary]

Mailing address: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_

hereby designate: \_\_\_\_\_ [Name of Authorized Representative]

Mailing address: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_

Relationship to Participant or Beneficiary \_\_\_\_\_ to act on my behalf or on

behalf of: \_\_\_\_\_ [Name of Dependent]

I authorize my Personal Representative to act for me and for my covered spouse and dependents (if named above) in receiving the following protected health information to conduct the following functions on my behalf:

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I understand that this designation is subject to approval by the Plan. I also understand that, once approved, this designation will remain in effect unless I revoke it. I understand that I have the right to revoke this designation at any time by submitting a signed statement to that effect to the Plan Office.

I certify that I have reviewed the Plan's Policy for Recognition of Personal Representative.

\_\_\_\_\_  
Participant or Beneficiaries' Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Representative's Signature

\_\_\_\_\_  
Date