



MCS Life Insurance Company  
P.O. Box 9023547  
San Juan, P.R. 00902-3547  
787.758.2500

**Appointment of Representative**

ENROLEE'S NAME

CONTRACT NUMBER

**SECTION 1: APPOINTMENT OF REPRESENTATIVE**

**To be completed by the enrollee**

As an MCS Life Insurance Company enrollee, I appoint \_\_\_\_\_, to act as my representative in matters regarding my <grievance or appeal>. I authorize this person to make any request, to present or to elicit evidence, to obtain grievances and/or appeals information, and to receive any notice in connection with my grievance and/or appeal, wholly in my stead. I understand that personal medical information related to my grievance or appeal may be disclosed to the representative indicated here.

Signature of enrollee		Date
Street Address		Phone Number (include Area Code)
City	State	Zip Code
Email Address (optional)		

**SECTION 2: ACCEPTANCE OF APPOINTMENT**

**To be completed by the representative**

I, \_\_\_\_\_, hereby accept the above appointment. I certify that I have not been disqualified, suspended or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary. I am the enrollee's \_\_\_\_\_(professional status or relationship to the party, e.g., attorney, relative, etc.).

Signature of Representative		Date
Street Address		Phone Number (include Area Code)
City	State	Zip Code
Email Address (optional)		