Appointment of an Authorized Representative

For Claims and Appeals

- ☐ Marathon Petroleum Health Plan
- ☐ Marathon Petroleum Dental Plan
- ☐ Marathon Petroleum Vision Plan
- ☐ Marathon Petroleum Health Reimbursement Account
- ☐ Marathon Petroleum Employee Assistance Program
- ☐ Marathon Petroleum Health Care Flexible Spending Account Plan
- ☐ Marathon Petroleum Exchange Health Reimbursement Account Plan
- ☐ Marathon Petroleum Retiree Health Plan
- ☐ Marathon Petroleum Pre-65 Retiree Dental Plan
- ☐ Marathon Petroleum Pre-65 Retiree Vision Plan
- ☐ Marathon Petroleum Life Insurance Plan
- ☐ Marathon Petroleum Level Premium Life Insurance Plan
- ☐ Marathon Petroleum Accidental Death & Dismemberment (AD&D) Insurance Plan
- ☐ Marathon Petroleum Occupational Accidental Death (OAD) Benefit Plan
- ☐ Marathon Petroleum Long-Term Disability Plan
- ☐ Marathon Petroleum Termination Allowance Plan

An Authorized Representative is a person you authorize to act on your behalf with regard to the Plan(s) selected above, in pursuing a claim or an appeal of a denied claim. This authorization may be either
(1) granted for a particular event or date of service, after which time the authorization approval is revoked, or
(2) granted for any present or future claim for health care or other benefit you may have. Designations of Authorized Representative status granted for a particular event or date of service are most appropriate when being granted to a health care provider or an attorney that may be representing you in connection with a claim. Designations of Authorized Representative status for any present or future claim for health care benefits are more appropriately made to family members or other trusted persons who you may wish to authorize to assist you in the future with health care claim matters.

I, _____, hereby appoint _____
(Name of person you are authorizing to act on your behalf) as an Authorized Representative, to act on my behalf in the filing or pursuance of claims and pursuance of appeals in connection with the following health care claims or other benefit (check one):

- ☐ _____ ; or
  (Description of claim(s) issue, date(s) of service, provider(s) of service, and any other pertinent information available)

- ☐ any present or future claim for health care benefits.

I understand that as a result of this authorization, the Plan may disclose and release information concerning benefit eligibility, claim status, or claim approval or denial reasons in connection with the above referenced health care or other benefit claim to the individual named above.

This designation is subject to revocation at any time by the designator except to the extent that the Plan has taken action in reliance on this designation before the Plan knew of the revocation. If not previously revoked, this designation will terminate on:

_____. (Specify date, time, event, and/or condition)

_____
Print name of patient/plan member

_____
Print name of personal representative, if applicable

_____
Signature of patient/plan member and date

_____
Signature of personal representative and date