PEOPLES HEALTH

A UnitedHealthcare Company

Limited Health Care Power of Attorney

I, _____, do name and appoint
Member Name

_____ to act on my behalf with respect to all
Designee's Name

business and health care transactions with Peoples Health including, without limitation, those involving health care decisions, medical expenses, changing my address, authorizing the use and disclosure of my protected health information, filing appeals and grievances on my behalf, and enrollment and disenrollment from Peoples Health. I understand that I may revoke this Limited Health Care Power of Attorney at any time by notifying Peoples Health verbally or in writing. A photocopy or facsimile copy of this Limited Health Care Power of Attorney shall be considered as valid and binding as an original. I have read and fully understand this Limited Health Care Power of Attorney.

Member Signature: _____

Member Printed Name: _____

Date: _____

Member ID Number: _____
(as printed on your People Health ID card)

Phone Number for Designee Appointed Above: _____

Return this completed form through one of the following methods:

In-Person: Peoples Health Medicare Center 3017 Veterans Memorial Blvd. Metairie, LA 70002 Monday – Friday 8 a.m. to 5 p.m.	**Mail:** Attn: Customer Service Dept. Peoples Health Three Lakeway Center 3838 N. Causeway Blvd. Suite 2500 Metairie, LA 70002	**Fax:** 504-849-6906