Wellmark Advantage Health Plan

Wellmark Advantage Health Plan, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.

AFFIDAVIT OF NEXT OF KIN

Use this form to manage the protected health information of someone who's passed away

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Enrollee ID of deceased member

The undersigned, being first duly sworn, disposes and states:

1. I am the next of kin of ____

   who died on or about the ___________ day of _____________________, 20________.

2. A copy of the decedent's death is attached.

3. My relationship to the decedent is ____.

4. No personal representative has been appointed for the decedent's estate in this state or elsewhere and no application for such appointment is pending in this state or elsewhere.

5. This affidavit is made in support of my request to facilitate claims payment. I agree and understand that, pursuant to federal law, Wellmark Advantage Health Plan or its affiliates will not release copies of the medical records of the decedent to me or allow me to change the address of record.

The foregoing is the truth to the best of my knowledge, information and belief.

Dated at ____________________, _________ this __________ day of ______________ , 20________.
City *State*

____
Signature

____
Print Name

____
Address

____
Telephone

____
Notary Public

____
My commission expires on

Mailing Instructions	**Faxing Instructions**
Please mail completed authorizations to: Wellmark Member Correspondence PO Box 260040 Plano, TX 75026	Please fax completed authorizations to: **1-800-456-9517**

Members who need additional assistance completing this form should call a customer service representative at the number on the back of their Wellmark Advantage Health Plan ID card.

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