BURBANK EMPLOYEES
RETIREE MEDICAL TRUST

DELEGATION OF AUTHORITY TO SUBMIT CLAIMS

Plan Participant Name: _____

Address:_____City: _____

State: _____ Zip: _____

Cell phone: _____ Home Phone:_____

Name of Family Member Authorized to Submit Claims:

_____

Address:_____City: _____

State: _____ Zip: _____

Cell phone: _____ Home Phone:_____

Email:_____

Relationship to Participant:_____

I hereby authorize the above-stated family member to submit claims to the Medical Expense Reimbursement Plan of the Burbank Employees Retiree Medical Trust ("Trust") on my behalf. I understand and agree that as a result of this authorization, the Trust may disclose and release information concerning benefit eligibility, claim status, or claim approval or denial (and the reasons for denial) to the authorized family member stated above. I understand that I may revoke this authorization at any time by written communication to the Trust Office, c/o Benefit Programs Administration, 1200 Wilshire Blvd. 5th Floor, Los Angeles, CA 90017 or via email at burbankcity@bpabenefits.com.

_____ _____
Participant Signature Date

_____ _____
Authorized Family Member Signature Date

***Please note that Participant's signature on this form must be notarized.**

CALIFORNIA ALL-PURPOSE ACKNOWLEDGEMENT

A Notary Public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of

State of California
County of _____ }

On _____, before me, _____, Notary Public,

personally appeared _____

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

SIGNATURE_____

PLACE NOTARY SEAL ABOVE

Though the information below is not required by law, it may prove valuable to persons relying on the document
and could prevent fraudulent removal and reattachment of this form to another document.

Description of attached document

Title of document: Delegation of Authority to Submit Claims

Document Date:_____Number of Pages:_____

Signer(s) Other than Named Above:_____