



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

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 certificate 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 may 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

Notary Public

Telephone

My commission expires on

Mailing Instructions	Faxing Instructions
Please mail completed authorizations to: Wellmark Advantage Member Correspondence PO Box 211501 Eagan, MN 55121	Please fax completed authorizations to: 1-866-429-6345

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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