BlueAdvantage
Administrators of Arkansas
An Independent Licensee of the Blue Cross and Blue Shield Association

Designation of Authorized Appeal Representative

Wal-Mart Stores, Inc. Associates' Health and Welfare Plan (the "Plan")

Plan Participant Name _____

Identification Number of Plan Participant _____

The Plan is a self-funded ERISA plan. The Plan will accept appeals only from you, the Plan participant, unless you properly designate someone else to appeal on your behalf. In order to properly designate someone else to pursue an appeal on your behalf, the Plan requires that you and the person you wish to designate as your Authorized Appeal Representative must each sign this form, indicating that both you and the person you designate as your Authorized Appeal Representative agree to the terms and conditions stated in this form. If you or your designated Authorized Appeal Representative do not agree to any statements or terms set forth in this form, do not sign this form.

Once you and your designated Authorized Appeal Representative have each signed this form and returned it to the Claim Administrator at the address listed below, please understand that you have authorized the following to occur:

1. By signing this form, you give permission for the Authorized Appeal Representative to exercise your appeal rights under the Plan.

2. Signature of this form also gives the Authorized Appeal Representative access to all of your medical information and claims for health care benefits under the Plan, to the extent that any of them are relevant to your appeal.

3. Signature of this form authorizes the Plan and any of its representatives, including the Claim Administrator for the Plan, BlueAdvantage Administrators, to communicate directly with the Authorized Appeal Representative with regard to your appeal, as well as all related information such as claims, medical records, explanations of benefits, telephone calls, correspondence, your address, telephone numbers, social security number and Plan identification numbers, premium payments or other Plan eligibility data.

4. Upon proper submission of this signed form, the Plan, via the Claim Administrator or otherwise, will communicate directly to your Authorized Appeal Representative – rather than to you – the Plan's decision regarding your appeal, as well as other information related to the appeal.

If you wish to designate an appeal representative, please complete parts A through D of this form and forward it to the Claim Administrator at the address shown at the bottom of this form.

A. IDENTIFICATION OF CLAIMS YOU WISH TO APPEAL.
Please list the claims you authorize the Authorized Appeal Representative to appeal for you:

Name of Health Care Provider	Date(s) of Service	Amount You claim is owed by Plan
_____	_____	_____
Name of Health Care Provider	Date(s) of Service	Amount You claim is owed by Plan
_____	_____	_____

NOTE: If all claims will not fit in the spaces provided above, you may submit an additional page, showing the requested details, however, the additional page MUST BE SIGNED AND DATED BY YOU or it will not constitute a valid authorization for the Authorized Appeal Representative to represent you with respect to appeal of any such identified claims.

B. IDENTIFICATION OF YOUR AUTHORIZED APPEAL REPRESENTATIVE

In the space below, enter the full name of your Authorized Appeal Representative, along with their address and telephone number.

_____

Name of Authorized Appeal Representative (Please Print)

_____

Address of Authorized Appeal Representative

_____

Telephone Number of Authorized Appeal Representative

C. YOUR SIGNATURE

_____

(Signature of Plan Participant)

_____

(Print Name)

_____

(Date Signed)

D. SIGNATURE OF AUTHORIZED APPEAL REPRESENTATIVE

The undersigned hereby accepts designation by the above-named Plan Participant to act as Authorized Appeal Representative. The undersigned understands and agrees that any claim for benefits allegedly due under the Plan, whether asserted on behalf of the Plan Participant or asserted by the undersigned on its own behalf as assignee or agent of the Plan Participant, is subject to and governed by the terms and conditions, policies and procedures of the Plan. The undersigned hereby agrees to abide by all terms and conditions of the Plan, including such allowances and payment limitations as the Plan, by its terms, may establish. In accepting this designation, the undersigned hereby represents that it will keep the Plan Participant fully informed on a timely basis of the status of any appeal and of all related communications exchanged with the Plan or its third party administrator, BlueAdvantage Administrators of Arkansas. The undersigned agrees to fully discharge the undersigned's obligations to the Plan Participant in acting as the Plan Participant's agent with respect to any appeal. Should the Plan Participant at any time indicate to the undersigned a desire to revoke this designation, the undersigned agrees to immediately cease acting on behalf of the Plan Participant, and to provide prompt, written notice of the same to the Plan and its third party administrator, BlueAdvantage Administrators of Arkansas.

_____

Signature of Authorized Appeal Representative

_____

Print Name

_____

Date Signed

E. ADDRESS OF CLAIM ADMINISTRATOR:

Please return this signed form to the Claim Administrator at:

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, AR 72203-1460