

**APPOINTMENT OF INDIVIDUAL TO ACT AS  
APPEAL REPRESENTATIVE**

I appoint \_\_\_\_\_ to act as my representative in connection with my appeal under Code of Federal Regulations, Chapter 32, Section 199.13, Appeal and Hearing Procedures. I further authorize the TRICARE Management Activity (TMA) and United Concordia Companies Inc., to release to said representative, information related to my dental treatment, and if necessary, photocopies of any dental records which may be required for adjudication of my claim for TRICARE Dental Program (TDP) benefits.

Please return the completed form to:

United Concordia Companies, Inc  
TDP Customer Service  
P.O. Box 69410  
Harrisburg, PA 17106-9410

\_\_\_\_\_  
**Beneficiary's Signature**

\_\_\_\_\_  
**Sponsor's Social Security Number**

\_\_\_\_\_  
**Date**