PROOF OF REPRESENTATION

Type of Medicare Beneficiary Representative (Check one below and then print the requested information)**:**

(**X**) Individual other than an Attorney**:** Name: **Blackburn Group Inc. and its representatives including but not limited to Robert J. Blackburn and Kathryn T. Blackburn**

(   ) Attorney* Relationship to the Medicare Beneficiary: **Medicare Vendor**

(   ) Guardian* Firm or Company Name: **Blackburn Group, Inc.**

(   ) Conservator* Address: **P.O. Box 142, Penfield, NY 14526**

(   ) Power of Attorney* Telephone: **585-586-4530**

Medicare Beneficiary Information and Signature/Date:

Beneficiary's Name (please print exactly as shown on your Medicare card): ____________________________

Beneficiary's Health Insurance Claim Number (number on your Medicare card): ________________________

Date of Illness/Injury for which the beneficiary has filed a Liability insurance, No-fault insurance or

Workers' Compensation claim: ________________________

Beneficiary Signature: _____________________________________Date signed: ____________________

Representative Signature/Date:

Representative's Signature: _________________________________Date signed: ____________________

Blackburn Group, Inc., P.O. Box 142, Penfield, NY 14526

Phone#: 585-586-4530