Designation of Authorized Appeal Representative

Walmart Inc. Associates' Health and Welfare Plan (the "Plan")

Plan/Plan Administrator	**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

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		Telephone	
Street or PO box	**City**	**State**	**ZIP**

C. YOUR SIGNATURE

Signature of Plan Participant

Print name

Date signed (mm/dd/yyyy)

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. The undersigned Authorized Appeal Representative further understands and agrees that the Plan does not pay billed charges or "usual, customary and reasonable" ("UCR") rates, but instead uses its own allowance which, in most cases, will be substantially less than billed charges or UCR. 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. The undersigned understands and agrees that neither this form nor Authorized Appeal Representative status confers any right to sue the Plan, the Plan Administrator, the Plan Sponsor or the Plan's Claims Administrator for any Plan benefits, and further understands and agrees that the Plan forbids assignment of benefits or any other Plan rights and limits the right to sue for Plan benefits to Plan participants and beneficiaries.

Signature of Authorized Appeal Representative

Print name

Print Title

Date signed (mm/dd/yyyy)

PLEASE NOTE: Failure to provide all of the above information, including but not limited to a legible, full name and title that signifies authority to bind the person or entity proposed for Authorized Representative status will invalidate this Authorized Appeal Representative designation, and the Plan or its Claims Administrator may decline, on that basis alone, to recognize the purported Authorized Appeal Representative.

E. ADDRESS OF CLAIM ADMINISTRATOR:

If your appeal is regarding a post service request, please return this signed form to the Claims Administrator at:

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

If your appeal is regarding a pre-service request, please return this signed form to the Claims Administrator at:

Fax: 501-379-1214
Email: urgentappeals@arkbluecross.com