

EMPLOYEE GROUP INSURANCE

Request for Accounting of Disclosures

Employee Group Insurance (EGI) recognizes an individual's right to request an accounting of certain disclosures made of his medical information.

1. Name: _____

2. Date of Birth: _____

3. Social Security No.: _____

4. Time period during which the accounting will cover:

Starting Date: _____ Ending Date: _____

Note: The starting date cannot be before April 14, 2003, and cannot be more than 6 years prior to the date this form is signed.

Unless otherwise noted on this from, I understand that the accounting will be mailed to me at the address below. I understand that I am entitled to my first accounting in any 12-month period free of charge but that any additional accounting requested may be subject to a cost-based fee. I also understand that if a fee will be imposed, I will be notified of the amount and will have the opportunity to withdraw or modify my request before receiving the accounting and incurring the fee.

Address of Requestor:

Contact Phone Number of Requestor:

Signature: _____ Date: _____

If the request is signed by a legal representative of the individual:

Printed name of legal representative: _____

Representative's authority to act for the individual: _____

If signed by a legal representative of the individual, please note that we must verify that you are this individual's legal representative for purposes of filing this Request. Please enclose any documents that support this authority (Power of Attorney, Court Order, etc). **EGI will verify that a person is the parent of a minor child, and therefore the legal representative of the child, based on the child's enrollment as the person's dependent minor child in a benefit plan offered by The University of Texas System in the absence of evidence that the person is not the child's legal representative.** As this person's representative, can you be contacted at the address, e-mail or phone number listed above? If not, please provide your mailing address, e-mail address and/or phone number below:

This form must be delivered, mailed or FAXED to the following:

ATTN:

Manager of Insurance Benefits/Contact Person
Employee Group Insurance
702 Colorado Street, Suite 6.600
Austin, Texas 78701
FAX Number 512/499-4620

For EGI Use Only

Name of person processing request: _____

Title of person processing request: _____

Date request received: _____ Deadline to respond: _____

Deadline extended? No

Yes: Reason: _____

Date written notification given: _____

New deadline to respond: _____

Date accounting sent: _____