

EMPLOYEE GROUP INSURANCE

Request for Confidential Communications of Medical Information

1. Name: _____
2. Date of Birth: _____
3. Social Security No.: _____
4. Description of the means by which and/or location to which you want EGI to provide you with communications containing Protected Health Information: _____

5. Description of the medical information to which the communications method will apply (check one):
 All medical information pertaining to the individual identified above
 Other. Please specify: _____
6. If this restriction would affect EGI or its Business Associates' ability to collect or make payment, please explain how payment would be handled under the proposed restriction:

7. Could disclosure of medical information other than as requested endanger you? Check one: Yes
 No

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). 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 phone number below:

For EGI Use Only

Person processing request: _____

Date request received: _____

Request: Granted Denied Date individual notified: _____

Method and destination of notification: _____