CONFIDENTIAL COMMUNICATION REQUEST FORM
California

This form is for use by a person who is covered by insurance and wishes to make a reasonable request to receive communications of insurance claim-related information from The Union Labor Life Insurance Company by alternative means or at alternative locations because the communications disclose medical information or provider name and address relating to receipt of sensitive services, or because disclosure of all or part of the medical information or provider name and address could endanger the person.

SECTION A: Covered individual requesting confidential communication:

Name: _____ Member I.D.: _____

Birth Date: _____ Relationship to Primary Insured or Subscriber: _____

Current Address: _____

SECTION B: To the covered individual – please read the following and complete the information requested.

You have the right to make a reasonable request that you receive communications of claim-related information from us by alternative means or at alternative locations if the communications disclose medical information or provider name and address relating to receipt of sensitive services, or disclosure of all or part of the medical information or provider name and address could endanger you. "Claim-related information" means all claim or billing information relating specifically to you, including your name, address, any services received, and the name and address of the provider of any services (such as your doctor). Your request will remain in effect until you revoke the request or submit a new request.

I, the covered individual, request that The Union Labor Life Insurance Company send communications of claim-related information to me by the following alternative means or at the following alternative locations because the communications disclose medical information or provider name and address relating to receipt of sensitive services, or disclosure of all or part of the medical information or provider name and address could endanger me:

In care of: _____
(If you are using someone else's address, then enter his or her name here.)
Alternative Address: _____

Alternative Phone Number: _____ Alternative Email Address: _____

Signature: _____ Date: _____

SECTION C: Parents, Guardians, or Legal Representatives

If the person making this request is the parent or guardian of a covered child younger than 18 years of age, please provide the following:

Parent or Guardian's Name: _____ Relationship to Covered Individual: _____

If a legal representative, such as an attorney, is making this request on behalf of the covered individual, then please provide:

Legal Representative's Name: _____ Relationship to Covered Individual: _____

Organization or Firm Name: _____

Business Address: _____

Business Phone Number: _____ Business E-mail Address: _____