

Request For Confidential Communications

Participant/Eligible Dependent's Name: _____ Birth Date: ____ / ____ / ____
MM / DD / YR

Address: _____

Home Telephone Number: _____ E-mail: _____

Participant Social Security Number: _____

I, _____, am requesting that AFTRA Health Fund ("Fund") communicate with me in the alternative manner and/or location described below regarding my health information.¹ Such request is necessary to prevent a disclosure that could endanger me. I understand that the Fund may deny this request if it imposes an unreasonable administrative burden.

Description of the Health Information that Must be Communicated Confidentially. The following is a description of the specific health information to which this request applies:

Alternative Manner and/or Location. I request that the Fund only communicate with me in the following manner and/or at the location described below:

By signing this form, I am confirming that it accurately reflects my wishes.

_____/_____/_____
Signature Date

If signed by Personal Representative:

Name of Personal Representative: _____

Relationship to Participant/Eligible Dependent or nature of authority: _____

Submit Form to:

Privacy Officer
AFTRA Health Fund
261 Madison Avenue
New York, NY 10016

¹ Information that constitutes Protected Health Information ("PHI") as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").