MEDAmerica

MedAmerica Insurance Company
Home Office: Pittsburgh, PA

MedAmerica Insurance Company of New York
Home Office: Rochester, NY

MedAmerica Insurance Company of Florida
Home Office: Orlando, FL

CONFIDENTIAL COMMUNICATION REQUEST

Purpose: For an individual to request, to avoid endangering that individual, we use an alternative location when communicating protected health information.

SECTION A: Individual Requesting Confidential Communication.

Name: _____

Current Address: _____

Date of Birth: _____ Policy Number: _____

SECTION B: Please read the following and complete the information requested.

You have the right to request that we communicate your protected health information using an alternative location to avoid endangering you. We will accommodate your request if it is reasonable and you state clearly that failure to communicate your protected health information to the alternative location could endanger you.

We will begin communications to the alternative location within three (3) business days of our receipt of this signed request. Any communications prior to this date will be sent using the existing address information.

We will revoke any authorization we have on file to release your protected health information that is dated prior to this request for confidential communications. You may submit a new authorization(s), if you choose, using the alternative location.

This form is valid only for the Policy Identification Number and individual specified above. If your Policy Identification Number changes, you will be required to submit a new request for confidential communication. If you have multiple coverages, you will be required to submit a form for each coverage. This form only applies to communications from us and does not apply to communications you may receive from other entities.

I request that you communicate with me about my protected health information at the following alternative location.

Alternate Address: _____

Alternate Telephone: _____ In Care Of (optional): _____

INDIVIDUAL'S SIGNATURE

I attest that failure to communicate my protected health information using the alternative location could endanger me.

Signature: _____ Date: _____

If this request is from a personal representative on behalf of the individual, complete the following:

Name: _____ Relationship: _____

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS.

RETURN THIS FORM TO:

Privacy Officer
Telephone: 1-800-544-0327 Ext.3413
E-mail: LTCPrivacy.Officer@MedAmericaLTC.com
Address: PO Box 41930, Rochester, New York 14604-0620