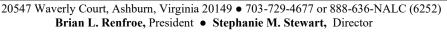
HIGH OPTION



NATIONAL ASSOCIATION OF LETTER CARRIERS

HEALTH BENEFIT PLAN





Request to Receive PHI at an Alternative Address

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, you have the right to request confidential communications of protected health information (PHI), if you believe disclosure of the information could result in harm to yourself or to others. Communication will be made by first class mail through the U.S. Postal Service. Please complete this form to make your request.

Section A - about the subject of	of the PHI (Patient)		
Member #	Patient's full name		
Patient's date of birth	Daytime ¡	ohone ()	
Patient's relationship to the enr (Examples:	ollee self, spouse, son, daughte	r, stepchild, foster chi	ld)
Section B - about you and you	r request <i>(Please print)</i>		
Your name			
Your relationship to the patient (Examples:	self, spouse, parent, child,	personal representati	ive)
Alternative mailing address			
City	State	Zip	
I believe that disclosure of my/t others; therefore, I am asking the	•		
Signature		Date	