

## REQUEST FOR ALTERNATE COMMUNICATIONS

### Information Regarding The Plan

“The Employer”	
“The Plan(s)”	

### Information Regarding The Person Making The Request

Your Name	
Address	
City/State/Zip	
Email	
Phone Number	

### The Request

Individual's Name	
What is your request?	
Check One	<input type="checkbox"/> I am the individual.
	<input type="checkbox"/> I am an authorized representative of the Individual.
<b>IF YOU ARE NOT THE INDIVIDUAL, WHAT IS YOUR REASON AND AUTHORITY TO MAKE THIS REQUEST?</b>	

I hereby request to receive communications of my protected health information (PHI) as described below. I understand that the Plan will agree to all reasonable requests but may condition the accommodation on factors such as standard payment methods and reporting.

Signed by: \_\_\_\_\_ Date Signed: \_\_\_\_\_

EMPLOYER/PLAN USE ONLY: