REQUEST FOR ALTERNATE COMMUNICATIONS

"The Employer"			
"The Plan(s)"			
Employee			
Address			
City/State/Zip			
Email			
Last 4 Numbers of Employee's Social Security Number		Employee's Birthdate (Month & Day) MM/DD	
Individual's Name			
Check One	_______ I am the individual.		
	_______ I am an authorized representative of the Individual.		

IF YOU ARE NOT THE INDIVIDUAL, WHAT IS YOUR REASON AND AUTHORITY TO MAKE THIS REQUEST?

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.

WHAT IS YOUR REQUEST?

PREFERRED EMAIL ADDRESS	
PREFERRED PHONE NUMBER	
PREFERRED MAILING ADDRESS	

Signed by: ____ Date Signed: _________________________

EMPLOYER/PLAN USE ONLY: