Cigna Global Health Benefits℠ HIPAA Request for Confidential Communication

This form will allow me, as a Cigna Global Health Benefits member/participant to request correspondences be forwarded to an Alternate Address.

I understand by completing and signing this form, I request Cigna Global Health Benefits to send all my correspondences to an alternate address that I will provide below. I understand all member/participant correspondences will be forwarded to this alternate address. I understand correspondences will continue to maintain my name; however, they will be forwarded to the address specified. We will accommodate reasonable requests whenever feasible. I understand my request for an alternate communication may be denied if not feasible. I understand an alternate address request may only be approved if my life could be endangered by the current communication.

Identification of member/participant requesting an Alternate Address. The following information is needed for verification.

Name of Member/Participant Requesting Alternate Address	Date of Birth	Member #

Subscriber Name (if different from Member)	Subscriber's Relationship to Member

Subscriber's Employer Name	Subscriber Member Number

Requested Alternate Address/Communication: ***(Address)***

____

Additional Request for Restriction:
(Should you wish to restrict this access to your IIHI, please indicate by checking the item below)

☐ **I request to restrict phone and Internet access to my Individually Identifiable Health Information (IIHI) to myself only.** ***(This would restrict the subscriber of benefits if not myself from phone access to my PHI).***

By signing this form, I hereby authorize Cigna Global Health Benefits to disclose the information according to the terms set forth herein. I understand that any form returned to Cigna Global Health Benefits incomplete will be returned to me for completion and my release of information to an alternate address may not occur until all the information is complete and processed.

I also understand that if either I, as a member/participant or my group subscriber changes health care benefits coverage or employers that I will need to resubmit this request. I understand if I have previously submitted a HIPAA Privacy Personal Representative request, my request for Alternate Address will take priority over that request. The most recently received and processed request will be utilized for communication purposes.

I understand that I may revoke this authorization by sending a written request to do so to the following address:

Privacy Office
Cigna Global Health Benefits
300 Bellevue Parkway
Wilmington, Delaware 19809

I have read and understand the above information:

Date: ________________ Signature of Authorizing Member/Participant: ______________________________

If patient is unable to give consent because of physical condition or age, complete the following: Patient is a minor of ______ years of age or is unable to give consent, because: ______________________________

Signature of Parent/Guardian/POA: ______________________________ Relationship: ________________

Please Note: By signing this application, I am attesting to the fact that disclosure of information to my current address could endanger me.

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