

CIGNA International Expatriate Benefits* HIPAA Request for an Accounting of Disclosures of Individually Identifiable Health Information

This form will allow me, as a CIGNA International Expatriate Benefits member/participant, to request an accounting of disclosures of my Individually Identifiable Health Information for purposes other than treatment, payment and/or health care operations and other exceptions under the Privacy Rule.

Effective as of April 14, 2003, CIGNA International Expatriate Benefits will provide an accounting of a member/participant's disclosures of individually identifiable health information for up to six (6) years prior to the date of the member/participant's request.

When a request for an accounting of disclosures of individually identifiable health information is received, it will be provided within sixty (60) days. If necessary, this time frame may be extended for thirty (30) days. The member/participant requesting the accounting will be informed in writing, within sixty (60) days of the original request, of the reason(s) for the extension and the date by which action will be taken upon the request.

A member/participant may receive an accounting of disclosures once during any twelve (12) month period at no charge. If a member/participant requests more than one accounting within the same twelve (12) month period, CIGNA International Expatriate Benefits may charge such member/participant a cost-based fee.

Identification of member/participant requesting an Accounting of Disclosures: The following information is needed for verification:

Name of Member/participant requesting an accounting of disclosures _____
 Date of Birth _____ Member # _____
 Subscriber's Name (if different from member) _____
 Subscriber's Relationship to Member _____
 Subscriber's Employer Name _____
 Subscriber's Member Number _____

Please return the signed and completed form to the following address: Privacy Office, CIGNA International Expatriate Benefits, 590 Naamans Road, Claymont, DE 19703

I understand that any form returned to CIGNA International Expatriate Benefits incomplete will be returned to me for completion and my request for an accounting of disclosures will not be implemented until all the information is received 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 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 _____

Signature of Personal Representative _____ Relationship _____

*CIGNA refers to CIGNA Corporation and/or one or more of its subsidiaries. CIGNA Corporation is a holding company and is not an insurance or an operating company. CIGNA International Expatriate Benefits ("CIEB") refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. Most employees are employed by such subsidiaries and not by CIGNA Corporation. CIGNA is a registered servicemark of CIGNA Intellectual Property, Inc., licensed for use by CIGNA Corporation and its subsidiaries.