



Request for Restriction of Use and Disclosure of Private Health Information

This form will allow me, as a CIGNA Medicare Rx* Member, to request a Restriction on the Use and Disclosure of my Private Health Information (PHI). I understand CIGNA Medicare ServicesSM will consider all requests for restrictions carefully; however CIGNA Medicare Services is not required to agree to a requested Restriction.

Note: If your request is granted, it will affect only written and oral communications by CIGNA Medicare Services. If you also wish another group health plan, physician or anyone outside of CIGNA Medicare Services to make this change, you must obtain their agreement separately.

VERIFICATION – (Please Print)

Identification of Member: (The following information is needed for verification. Please complete all applicable items.)

Name of Member: _____ Date of Birth: _____

Current Address on file: _____

Phone number where we can reach you if we need to contact you to process your request (required):

Medicare ID #: _____ Member ID card # (if applicable): _____

CIGNA Medicare Services will not disclose confidential information without your authorization unless it is necessary to provide your health benefits, administer your benefit plan, to support CIGNA Medicare Services programs or services, or as otherwise required or permitted by law. We will not, for example, give your confidential information to a credit agency, a telemarketer or a prospective employer. We will not sell, rent or license the confidential information you provide to us. You do not need to request a restriction if you are concerned about those uses and disclosures.

REQUESTED RESTRICTIONS

- Please describe your request: _____

VERIFICATION QUESTIONS (This section applies only to requests for access restrictions.)

The answers you provide below will be used to verify your identity if you call for your Private Health Information. Note that we ask these questions because the answers should be easy for you to remember, but you may enter other numbers as described below.

Last 4 digits of your favorite credit card (you may use any four digit number): ____ ____ ____ ____

What is your mother's date of birth? (answer in the following 8-digit format: 11231949 for November 23, 1949): ____ ____ ____ ____ ____ ____ ____ ____.

You may use any date, however, it cannot be a future date, and it must be a legitimate calendar date.

For example, we cannot accept 11361949 (November 36, 1949) because there are not 36 days in November. We also cannot accept 11232010 (November 23, 2010) because 2010 is a future date.

- Please DO NOT provide anyone else with the answers to these questions.

YOUR PREFERENCES

You are not required to complete this section. You should only complete this section if you wish to request not to be contacted regarding programs offered by CIGNA Medicare Services, its agents or subsidiaries as specified on this form except where required for administration of the benefit plan, by law or in direct response to your request or inquiry. Important: Even if you choose this restriction, CIGNA Medicare Services must still contact you with specific information related to your benefit plan or where required by law.

If you wish to proceed with this particular request, please check the types of outreach that you wish to restrict from the list below:

- Global Opt Out** – I elect not to receive any phone or written contact from CIGNA Medicare Services medical, vision, pharmacy, behavioral health and dental programs except where it is required for administration of the benefit plan or by law.
- E-Mail** – I elect not to receive e-mail correspondence.
- Surveys** – I elect not to receive surveys for any reason, except where required for the administration of the benefit plan or by law or in direct response to my request or inquiry.
- Printed Materials** – I elect not to receive printed materials, including educational materials, brochures and newsletters, except where required for administration of the benefit plan, by law or in direct response to my request or inquiry.
- Letters and Correspondence** – I elect not to receive any letter or correspondence except where required for administration of the benefit plan, by law or in direct response to my request or inquiry. This includes routine preventive health reminders.
- Phone Calls** – I elect not to receive any phone calls, except where required for the administration of the benefit plan and/or by law or in direct response to my request or inquiry.

Please Complete Next Page

PLEASE NOTE

- Communications, including communications containing PHI, will continue to be sent to the current address we have on file for you.
- If any information on this form is not complete, CIGNA Medicare Services will return the form to you, and your restriction request will not be considered until CIGNA Medicare Services receives complete information.
- If your date of birth is changed in our system or your CIGNA Medicare Services ID changes, a new form must be completed at that time.
- You may change or revoke this restriction by sending a written request to CIGNA Medicare Services, at the address shown below. You can obtain a Change/Revoke form by calling CIGNA Medicare Services at the number on your CIGNA Medicare Services ID card.

SIGNATURE

I have read and understand the above information. Date: _____

Signature of Member, Parent/Guardian, Personal Representative: _____

Relationship if signed by other than Member: _____

Note that, if not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete.

If request is made by a Parent/Guardian, complete the following: Member is a minor _____ years of age.

If you are a parent or guardian requesting a restriction on a child that will prevent the child's other legal parent from accessing the child's Private Health Information, you must:

1. provide evidence that the parental rights of the other parent have been terminated, or
2. obtain the other parent's agreement to this restriction. If you obtain the other parent's agreement to this restriction, please have the other parent sign this form and notarize it, or send a statement signed and notarized by both parents indicating that both parents have agreed to place a restriction on the child's Private Health Information.

Please Maintain a copy of this form for your records.

Please Return This Completed Form To:

CIGNA Medicare Services • PO Box 269005 • Weston, FL 33326-9927

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