Cigna Healthcare, Global Health Benefits℠ HIPAA Request for Confidential Communications or Restrictions Form

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

I understand by completing and signing this form, I request Cigna Healthcare, Global Health Benefits to request to receive communications of Protected Health Information (PHI) about me by alternative means or at alternative locations and request a restriction on the use and disclosure of my PHI. We will accommodate reasonable requests whenever feasible.

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

Name of Customer/Participant Requesting Alternate Address _____ Date of Birth _____ Customer ID Number _____

Subscriber Name (if different from Customer) _____ Subscriber's Relationship to Customer _____

Subscriber's Employer Name _____ Subscriber Customer Number _____

Requested Alternate Address/Communication: *(Address)*

_____

Telephone Number _____ Email Address _____

Additional Request for Restriction:

(Should you wish to restrict this access to your information, please indicate by checking the item below)

☐ I request to restrict phone and Internet access to my Protected Health Information (PHI) to myself only. If you make this election and you are not the Subscriber, you will not be able to access your information on the Internet. You will need to call the number on your or the Subscriber's ID card to obtain information by phone. (The Subscriber will still be able to obtain his/her own PHI via phone and Internet.) Important: If you wish to implement this type of restriction, you must complete the verification question section on page 2.

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 protected 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.

4-digit PIN (you may use any 4-digit number): _____

What is your mother's date of birth? _____

Please Complete Next Page

(Please 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 11232030 (November 23, 2030) because 2030 is a future date.

- Please DO NOT provide anyone else with the answers to these questions.
- You should keep a copy of this form for reference

Please Note

- If you are not the Subscriber, any check payment for services you receive that is not sent to the health provider will be sent to the Subscriber. Therefore, a Subscriber may receive a check that may prompt questions to you about the services rendered.
- Communications containing your PHI will be sent to the address you have provided on this form.
- If the information on this form is not complete, Cigna Healthcare, Global Health Benefits will return the form to you, and this request may not be considered until we receive complete information.
- If either the Customer or Group changes to a different type of health care benefits coverage provided by Cigna Healthcare, Global Health Benefits another form will need to be completed at that time.
- You may change or revoke this request by sending a written request to Cigna Healthcare, Global Health Benefits at the address at the end of this form. If you wish to change or revoke this request, you must provide the updated address that you wish to use going forward.

Signature

I have read and understand the above information:

(Print name)_____ Date: _____

Signature of Customer, Parent/Guardian, Personal Representative if available:

_____

Relationship if signed by other than Customer: _____

Note that if not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete, including furnishing a copy of the health care power of attorney or other relevant document.

If unable to give consent because of age, complete the following, Customer is a minor_____ years of age. If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

Please complete and return this form to the following address:

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