SEAFARERS HEALTH AND BENEFITS PLAN
5201 Auth Way
Camp Springs, Maryland 20746
1 (800) 252-4674
Request For Confidential Communications

Participant Name: _____ Date of Birth: _____/_____/____

Address: _____
_____
_____

Daytime Phone Number: _____
Evening Phone Number: _____ Social Security Number: _____

I am requesting that the Plan communicate with me by alternative means and/or at an alternative location. I am making this request because I believe that the disclosure of my protected health information could endanger me. I understand that the Plan may deny this request.

I am requesting confidential communications in respect to the following protected health information:

_____

_____

I am requesting that you communicate with me by the following alternative means:

_____

_____

I am requesting that you communicate with me at the following alternative location:

_____

_____

_____

Signature of Participant: _____Date ____/____/____

If signed by personal representative:
Name of personal representative: _____

Relationship to participant or nature of authority: _____

_____ _____/_____/_____
Signature of Personal Representative Date