

**SEAFARERS HEALTH AND BENEFITS PLAN**

**5201 Auth Way**

**Camp Springs, Maryland 20746**

**1 (800) 252-4674**

**Request to Amend Protected Health Information**

Participant Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_

Evening Phone Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

I am requesting that the Plan amend the following protected health information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I am requesting that the Plan amend this information in the follow way:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that if the information that I am requesting be amended was not created by the Plan, the Plan may deny this request.

I also understand that if the information that I am requesting be amended, is determined by the Plan to be accurate and complete, the Plan may deny this request.

I further understand that the Plan may deny my request if the information that I am requesting be amended is not contained in the designated record set or if I do not have the right to amend the information.

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