SEAFARERS HEALTH AND BENEFITS PLAN

5201 Capital Gateway Drive
Camp Springs, Maryland 20746-4275
(301) 899-0675

Margaret R. Bowen
Administrator

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

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

Social Security Number: _____

Address: _____

_____

_____

Daytime Phone Number: _____ Evening Phone 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