MOTION PICTURE INDUSTRY
PENSION & HEALTH PLANS™

PARTICIPANT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Participant Name:_____ Social Security Number: _____

Address: _____

_____

Home Telephone Number: _____ Work Telephone Number: _____

E-mail Address: _____ Participant Birth Date: _____

I am requesting that the MPI Health Plan communicate with me in the alternative manner and/or location described below regarding my health information (information which constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996). Such restriction is necessary to prevent a disclosure that could endanger me. I understand that the MPI Health Plan may deny this request if it imposes an unreasonable administrative burden.

Description of the Health Information that Must be Communicated Confidentially. The following is a description of the specific health information to which this request applies:

_____

_____

Alternative Manner and/or Location: I request that the MPI Health Plan only communicate with me in the following manner and/or at the location described below:

_____

_____

By signing this form, I am confirming that it accurately reflects my wishes.

_____ ____/____/____
Participant Signature *Date*

If this Request for Confidential Communications is to be signed by a personal representative, that personal representative must also sign below before submitting this form to the MPI Health Plan.

If signed by personal representative, name of personal representative: _____

Relationship to Participant or nature of authority:_____

_____ ____/____/____
Signature of Personal Representative *Date*

THIS REQUEST MUST BE COMPLETED IN FULL BEFORE BEING SUBMITTED