CareConnect
Healthier Insurance™

REVOCATION OF CONFIDENTIAL COMMUNICATIONS BY ALTERNATIVE MEANS OR ALTERNATIVE LOCATION

Purpose: This Form is intended for use by an individual to revoke a request previously given to CareConnect Insurance Company, Inc. ("CareConnect") for confidential communications by alternative means or at an alternative location.

SECTION A: Member requesting. (Please Print)

Member's Name: _____

Address: _____

Member Identification Number: _____ Date of Birth: _____

Group or Account # on ID card: _____

Phone number where we can reach you to process your request (required): (____) ____ - _____

SECTION B: Please read the following and complete the information requested.

☐ **I revoke my previous Request for Alternative Means or Location of Confidential Communications effective** _____ *(Please insert a prospective date no earlier than fifteen (15) business days from the date that you send this request)*

I understand that this revocation *will not* affect actions taken in accordance with my confidential communications request prior to receipt of this written revocation. I also understand that when this revocation becomes effective, the restrictions previously requested will no longer be in place.

SECTION C: Signature

If this request is from the **Member,** please complete the following:

I have read the above statement and attest that I no longer need to receive confidential communications by alternative means or at an alternative location as previously requested.

_____

(Signature) (Print)

Date: _____

If this request is from a **Personal Representative** on behalf of the Member, please complete the following :

I have read the above statement and on behalf of the member attest that the member no longer needs to receive confidential communications by alternative means or at an alternative location as previously requested.

_____

(Signature) (Print)

Relationship to Individual: _____ Date: _____

Personal Representative: If you are not the member or parent of the minor member, please attach proof of your relationship to the member. We will require verification of your authority to act on the member's behalf before this request will be considered complete.

Please attach copies of your authorization as required by state law to represent the member – for example, health care proxy or guardianship papers.

Please return this completed form to:

CareConnect Insurance Company, Inc.
Attention: Privacy Officer
2200 Northern Boulevard, Suite 104
East Hills, NY 11548

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS.