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REQUEST FOR CONFIDENTIAL COMMUNICATIONS BY ALTERNATIVE MEANS OR ALTERNATIVE LOCATIONS

About You

Subscriber Name: ______________________________

Address: ______________________________

Subscriber ID Number: ______________ **Telephone Number:** ______________

Member Name: ______________________ **Date of Birth:** ______________

Please place a check mark in front of each plan you want the Confidential Communications to be applied:

GEHA Health Plan

GEHA Connection Dental Federal Plan

Connection Dental *Plus* Plan

CONNECTION Vision Plan

New Contact Information

New Address: ______________________________

New Telephone: ______________________________

Reason for Request: ______________________________

Signature and Acknowledgement

- I understand that any request GEHA accepts will be limited to information under GEHA's control, and the request will be communicated to GEHA's Business Associates.
- I have the right to request GEHA terminate the confidential communication to the extent that such termination applies to information created or received after the date of termination, by contacting the Privacy Office at the address below or at privacyofficer@geha.com.

Date: ______________

Member or Legal Representative Signature: ______________________________

Relationship to member: ______________________________
(i.e. parent, legal guardian, power of attorney, etc.)

NOTE: If the signature is not that of the member or the parent when the child is a minor, appropriate legal documentation is required to accept the signature.

PLEASE RETAIN A COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL SIGNED FORM TO:

ATTN: Confidential Communications Request
GEHA
P.O. Box 21542
Eagan, MN 55121
FAX: 816.257.3283