REQUEST FOR ALTERNATE COMMUNICATIONS

Date:_____

Name:_____

I. Request for Restriction

I hereby request that I receive communications of my protected health information from any of the following Plan sponsored by Illinois Educators Risk Management Program Group Health Plan the "Plan"), as follows:

Specifically, I request that the following communications be subject to the above request:

_____

Alternative means of contact: _____

**The disclosure of all or part of the information to which this request pertains could endanger me.

II. Other Important Information

I understand that the Plan will agree to all reasonable requests, but may condition this accommodation on, when appropriate, information as to how payment, if any, will be handled; and my specifying above an alternative means of communication.

III. Signature of Individual or Individual's Representative

_____ _____

Signature of individual or individual's representative **Date**

(Form MUST be completed before signing.)

Printed name of the individual's personal representative:

_____

Relationship to the individual, including authority for status as representative:

_____