Group Insurance Trust of the
California Society of Certified Public Accountants
Request for Confidential Communication of Health Information

Please provide the information below. We cannot respond to your request without this information.

Your name: ____

Employee's name: ____ Employee's ID:__________________

Best way to contact you: ____

Health Plan communications are normally mailed to the address on record with the Health Plans. Use this form if you want the Health Plans to send communications containing your health information via another means (e.g., by fax) or to another location (e.g., your work address). Due to administrative constraints, the Health Plans may not be able to honor your request. **However, we will accommodate all reasonable requests if you believe that you would be endangered if your health information was disclosed in the standard way.**

This request applies to my following health information (describe the specific information or category of information):

____

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Please send the above health information by this alternative means or to his alternative location:

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If you believe that the denial of this request could put you in danger, please write the following on the lines below: **"Disclosure of my health information described above without my requested accommodation could put me in danger."** Otherwise, explain your need for disclosure.

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Apply the requested restriction to the following Health Plan(s):

- ❑ CalCPA Health Medical Plans (PPO)
- ❑ CaliforniaCare Medical Plan (HMO)
- ❑ Vision Service Plan (Vision Plan)
- ❑ Delta Dental (Dental Plan)
- ❑ Other

The Health Plans will notify you that your request has been either granted or denied.

For internal use only:
❑ Approved   Notice of extension sent: ______________________________
❑ Denied   Date received: ______________________ Response Date: ____________________

Policy Attachment ______   10452739

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I hereby request confidential communication of my health information, as described above. I understand that the Health Plans are not required to agree to my request unless (1) my request is reasonable, and (2) I have stated on this form that I could be in danger if my request is denied. If my request is granted, I understand that communications in accordance with my request will continue until I notify the Health Plans that the alternate communication is no longer necessary, or until I am notified by the Health Plans that communications will resume in the normal form.

_______________________________________ Signature*

______________________ Date

**If you are making this request on behalf of another individual, a completed Personal Representative Form must be on file with the Health Plans unless you are the individual's parent or guardian and you are also a participant in a Health Plan.*

Send this completed request form to:

Banyan Administrators, LLC
Managers for the CalCPA Health Programs
1215 Manor Drive, Suite 200
Mechanicsburg, PA 17055
Fax – (877) 237-4519
CalCPAHealth@fnrm.com

If you have questions about this form or your right to request to inspect or receive copies of your health information, contact Banyan Administrators, LLC at (877) 480-7923.