Part I - Request for Confidential Communications of Personal Health Plan Information

Form Received By ______ Date ______

Check One:
☐ Allied Pilots Association Voluntary Supplemental Medical & Custodial Care Benefit Plan (the "Plan")
☐ Allied Pilots Association Catastrophic Major Medical Benefit Plan (the "Plan")
☐ Allied Pilots Association Employee Health Benefit Plan (the "Plan")

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations. If the Payment of benefits is affected by this request, the Plan may also deny this request unless you contact the Privacy Official to discuss alternative Payment means.

1. Member or Employee Name:	1a. Member or Employee Number:
1b. Member or Employee Date of Birth:	1c. Your Name:
2. Name of Person Whose Records You Are Requesting:	2a. Relationship to Member or Employee: Employee ☐ Spouse ☐ Child ☐ Other ☐
3. Address:	3a. Your Relationship to Person in Box 2: Self ☐ Spouse ☐ Parent ☐ Child ☐ ☐ Other (please describe relationship):

I am requesting that communication of personal health plan information for the person in Box 2 be provided by alternative means or at alternative locations. **[check one]** I [☐ am ☐ am not] making this request because disclosure of all or part of the information to which the request pertains could endanger me, or the person I represent.

Please send the information by the following alternative means: ______________________

Please send the information to the following alternative address, if different than address above:

Street address ______________________
City, State and Zip code ______________________
Phone ______________________
Other ______________________

If this request relates to communication regarding Payment for health care services, please indicate how we can reach you to discuss alternative Payment means.

Please return completed form to: HIPAA Privacy Official
Allied Pilots Association
14600 Trinity Blvd., Suite 500
Fort Worth, TX 76155
Fax 817-302-2146

______________________ ________
Signature Date

Part II - Determination of Request for Confidential Communications of Personal Health Plan Information

Form Part II Prepared By ______ Date ______

After reviewing your request for Confidential Communications of personal health plan information, the Plan has made the following determination:
☐ **Request Approved** (see section A below) ☐ **Request Denied** (see section B below)

Section A: Request Approved

The Plan accepts your written request for the use of alternative means or alternative locations for Confidential Communications of personal health plan information The Plan will send personal health plan information:
☐ By the alternative means you specified in Part I; and/or
☐ To the alternative address you specified in Part I.

Section B: Request Denied

The Plan denies your written request for the use of alternative means or alternative locations for Confidential Communications of personal health plan information for the following reasons:

☐ The Plan has determined that the request is incomplete.
☐ The Plan has determined that the request is not reasonable
☐ The request does not clearly state that the Plan's usual means or locations of disclosure of personal health plan information poses a danger to you (or to the person in Box 2).

______________________ ______________________ ______________________
Name of Plan Representative Signature of Plan Representative Date of Determination