

CONFIDENTIAL COMMUNICATION REQUEST FORM

You have the right to request that affiliated entities AultCare Corporation, AultCare Health Insuring Corporation (AHIC) which also does business as PrimeTime Health Plan, Aultra Administrative Group (AAG), and AultCare Insurance Company (AIC) which also does business as AultCare HMO, communicate with you on a confidential basis by requesting an alternative means or alternative location to receive our communications. For instance, you may request that we will only call you at work. We will accommodate all reasonable requests. If you wish us to contact you at an address or phone number other than your home address or home telephone, please provide the following information:

_____ Member Name	_____ Date
_____ Group Number	_____ Member ID Number
_____ Address to receive communications: _____ _____	_____ Alternate Phone number: _____

Do you believe that without such alternative communication, the disclosure of some or all of the information could endanger you? *

_____ Print Name	_____ Date
_____ Signature**	_____ Date

** This form will only change how we communicate to you via mail or phone. If you would like to specifically restrict someone from accessing your information, please complete the **Member Request to Restrict Uses & Disclosures of PHI Form**.*

*** Note we will not process any requests that are not signed by you or your representative. If you are the member's representative, please provide documentation or explanation of your authority to act for the member. If you do not have such documentation, please complete the **Authorization for Release of Information Form**.*