

**Southern California IBEW-NECA Trust Funds**  
**Sample Form Letter: Participant Request For Confidential Communications**

Participant Name: \_\_\_\_\_

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM / DD / YR

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Participant Identification Number and/or Social Security Number: \_\_\_\_\_

I, \_\_\_\_\_, am requesting that Southern California IBEW-NECA Health Plan communicate with me in the alternative manner and/or location described below regarding my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996). Such restriction is necessary to prevent a disclosure that could endanger me. I understand that Southern California IBEW-NECA Health Plan may deny this request if it imposes an unreasonable administrative burden.

Description of the Health Information that Must be Communicated Confidentially. The following is a description of the specific health information to which this request applies:

\_\_\_\_\_  
\_\_\_\_\_

Alternative Manner and/or Location. I request that Southern California IBEW-NECA Health Plan only communicate with me in the following manner and/or at the location described below:

\_\_\_\_\_  
\_\_\_\_\_

By signing this form, I am confirming that it accurately reflects my wishes.

\_\_\_\_\_  
Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

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If signed by personal representative:

Name of personal representative: \_\_\_\_\_

Relationship to participant or nature of authority: \_\_\_\_\_

\_\_\_\_\_

Signature of Personal Representative

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Date

***Submit Form to: Privacy Officer, Southern California IBEW-NECA Health Plan***  
**515 South Avenue 19, Los Angeles, California 90031**