CONFIDENTIAL COMMUNICATIONS REQUEST FORM

Complete this form and return to: Privacy Compliance Administrator, Corporate Compliance, Capital District Physicians' Health Plan, Inc., 500 Patroon Creek Blvd., Albany, NY 12206-1057 or Fax: 518-641-5504

NOT FOR USE WHERE REQUEST IS DUE TO THREAT OF HARM.
CONTACT CDPHP MEMBER SERVICES IN CASES OF THREAT OF HARM.

I. MEMBER INFORMATION

Date of request: _____ Date of Birth:_____

Name:_____

CDPHP Identification #:_____ Telephone Number:_____

II. ADDRESS INFORMATION

Confidential Address Request. I am requesting that all CDPHP mailings be sent to the following address:

_____

_____

Alternative Means of Communications. I am requesting to receive confidential communications from CDPHP in the following format:_____

III. DEPENDENT INFORMATION

I am requesting that the address on file with CDPHP be updated as indicated above for all of the members listed below:
Please note: In order for confidential addresses to be accepted for members 18 years old and older, each member must complete and sign a Confidential Communications Request Form.

_____	_____
Name (please print)	*CDPHP ID#*
_____	_____
Name (please print)	*CDPHP ID #*
_____	_____
Name (please print)	*CDPHP ID#*

IV. SIGNATURE

I am requesting this change in my capacity as *(select one):*
___ Self ___Parent ___Guardian ___Legal Representative *(attach signed authorization form)*
___Other (explain):_____

Signature of member
or legal representative_____ Date_____