



Request for Confidential Communication of Protected Health Information from US Able Life

PO Box 1650
Little Rock, AR 72203-1650

You have the right to request that your protected health information maintained by US Able Life be communicated to you in a confidential or alternate manner. The request must be in writing, and you may use this form to make sure all required information is included. You are not required to use this form but must include all information below for the request to be processed. You may make your request by phone in an emergency situation. A phone request must be followed with a written request to be effective.

The request must be in writing, and must contain the following information:

Insured's Full Name: _____

Insured's Date of Birth: _____

Insured's Policy Number: _____

Line of Business: Accident Cancer Critical Illness
 GAP Heart & Stroke Hospital Indemnity

Current Address
Street _____

City State Zip Code

New Address you wish to use: Street _____

City State Zip Code

Daytime phone number where we can contact you: _____

Reason you are requesting confidential communications:

The request must be mailed or faxed to the US Able Life Privacy Office at:

P.O Box 1650
Little Rock, AR 72203-1650
Fax number: (501) 235-8484
Telephone number: (501) 212-8871 or (800) 648-0271, Extension 8871
E-mail: privacyofficer@usablelife.com

Please note that claims or correspondence processed prior to the change of address effective date will be sent to the old address.

Effective Date

You will receive a confirmation notice or request for more information at the new address you have indicated. The change will be in place after you receive the acknowledgement from us. Until that time, you must assume that all correspondence will go to the original address.

Cancellation of Address Change:

To cancel the change of address, a written request must be received and processed by the Privacy office. When a confidential communications order is cancelled, all information will once again be available to the policyholder.

Signature: _____ Date: _____