THE NELSON TRUST

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Health Care Information Non-Disclosure Request

Instructions:

Use this form to request us not to share your personal information with certain parties. These parties include those we would normally share information with for treatment, payment or health-care operations relating to you such as:

- your former doctor or other health-care provider
- persons or family members directly involved in your care or payment for your care.

In some cases, we may not be able to honor your request. For example, state or federal law may prohibit such restriction.

You can also use this form to ask us to mail documents containing your personal information to a different (alternate) address from the one we have listed for you. This includes documents such as Explanations of Benefits (EOBs).

Please complete the form and return it to us at the address shown. Do **not** use this form to submit a permanent change of address. For permanent change of address, call Customer Service.

If you submit an alternate address on this form, we will continue to maintain the original address for your account. However, all mail containing your personal information will come to the address you give us on the form. This alternate address will stay in effect as long as you stay with your current plan.

Rest assured that we share only the information about you needed to take care of your health-care business or as required by law. For more information on how your information may be disclosed, see the Notice of Privacy Practices on The Nelson Trust and Premera Web sites at:

- *www.nelson.aibpa*, located under View and Print forms in the Active and Retiree sections
- *www.premera.com*, or call Premera Customer Service at the number on the back of your ID card for a paper copy.

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Please note: Do not use this form to submit a permanent change of address. For permanent change of address, call Customer Service.

This form must be filled out completely before we can evaluate it. The evaluation may take up to 15 working days. We will send a letter explaining our decision to the address listed in section C below. Please keep a copy of this form for your records.

A. IDENTIFYING INFORMATION

Identity of Member

Birth Date: _____ (MM/DD/YY) Social Security Number: _____-_____-_____

Member Name: _____ (First/MI/Last) Member #: _____

Current Address: _____ City: _____

State: _____ ZIP: _____ Phone: (_____) _____

Subscriber Name: _____ (First/MI/Last) Subscriber Group Number: _____

Identity of Requester (if other than Member). Must be the member's parent, legal guardian or holder of power of attorney. If legal guardian or holder of power of attorney, a copy of the court order of legal guardianship or notarized power of attorney must accompany this request.

Requester's name: _____ (First/MI/Last) Relationship to member: _____

B. WHO SHOULD NOT BE ALLOWED ACCESS TO YOUR INFORMATION

This request for non-disclosure must identify a specific person. If this person is a previous health care provider, we may need to continue to disclose information for the payment of health-care services rendered to you by that provider.

Name: _____

Relationship to Member: ☐ Spouse ☐ Parent/Legal Guardian ☐ Previous Health-Care Provider

Reason for Non-Disclosure Request: ☐ Personal Safety ☐ Other: _____

C. ALTERNATE MAILING ADDRESS

Indicate where you want us to send written communication containing your personal information (including Explanations of Benefits):

☐ Your current address listed as above in section A *OR* ☐ Alternate mailing address:

Alternate Address: _____ City: _____

State: _____ ZIP: _____

For office use only—Date received: _____ Received by (initials):_____

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D. INFORMATION NOT TO DISCLOSE

Indicate below the categories of information that you do not want disclosed:

☐ Alcohol/Chemical Dependency

☐ Reproductive Health (including abortion)

☐ Sexually Transmitted Disease (including HIV/AIDS)

☐ Mental Health

☐ General Health Information

☐ Other: _____

Note: In order to fulfill this request, it may be necessary to suppress information beyond the category/categories you have indicated above.

E. PAYMENT

If this request is granted, you will be responsible for financial obligations (including, copayment, coinsurance and any benefits owed to providers) related to your current coverage with us.

F. TIMEFRAME FOR HONORING THIS NON-DISCLOSURE REQUEST

You understand that this request applies only to your current coverage and will remain effective unless you notify us in writing. You also understand that your information may have been shared with the person indicated in section B prior to this request and while this request is being processed. We will not be liable for any of these disclosures.

Signature: _____ Date: _____

Print name: _____

Send this form completed to:

Administration Office
The Nelson Trust
PMB #116
5331 S Macadam Ave, Ste 258
Portland, OR 97239

For office use only—Date received: _____ Received by (initials):_____