

**ASSOCIATED BENEFITS CORPORATION**  
**HIPAA Privacy Practices Complaint Form**  
(Health Plan)

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Purpose: This form is used for an individual to lodge a complaint about our privacy practices or compliance.

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**To the individual lodging complaint:**

You have the right to file a complaint with us about our privacy practices or our compliance with our Privacy Practices Notice, our Privacy Policies and Procedures, or federal or state privacy rules or law. We will investigate your complaint and provide you our written response. We will not require you to waive any right you may have under federal or state privacy or other law to file your complaint, nor will filing your complaint adversely affect your enrollment in our health plan, your eligibility for benefits under our health plan, or our payment of your claims under our health plan. To exercise this right, please complete, sign and date Sections A and B below, then submit this complaint to us at:

Contact Office: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Address: \_\_\_\_\_

If you have questions, need additional information or assistance in completing your complaint, please contact us at the above location. You may, in addition or in the alternative to filing a complaint with us, file a complaint with the United States Department of Health and Human Services. For information on the procedures for doing that, please contact us at the above location.

**SECTION A: Individual lodging complaint.**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Identification Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**SECTION B: Individual's complaint.**

Please give a concise, plain statement of your complaint:

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Please give a concise, plain statement of the resolution you seek for your complaint:

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**INDIVIDUAL'S SIGNATURE:**

I certify that the statements made in this complaint are true and correct to the best of my information and belief.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this complaint is lodged by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS COMPLAINT. PLEASE RETAIN A COPY FOR YOUR RECORDS.**

**MAIL TO:** ASSOCIATED BENEFITS CORPORATION, HIPAA PRIVACY OFFICE, P.O. BOX 71039, DES MOINES, IOWA 50325-0039

**ASSOCIATED BENEFITS CORPORATION**  
**COMPLAINT INVESTIGATION AND PROCESSING**

Date complaint received: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date complaint transmitted to Privacy Official: \_\_\_\_/\_\_\_\_/\_\_\_\_

Investigation undertaken: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Findings and Conclusions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If noncompliance found, corrective action instituted (including sanctioning any workforce member violating Privacy Policies and Procedures, Privacy Rules or other federal or state law, and mitigating any deleterious effect of the noncompliance):

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

Report on Complaint sent on \_\_\_\_/\_\_\_\_/\_\_\_\_. Attach copy of Report on Complaint.

Matter concluded and closed on \_\_\_\_/\_\_\_\_/\_\_\_\_.

**SIGNATURE.**

I attest that the above information is correct.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print name: \_\_\_\_\_

Title: \_\_\_\_\_