



ASSOCIATED BENEFITS CORPORATION

AMENDMENT REQUEST

Purpose: This form is used for an individual's request to amend protected health information or records in our designated record sets or the designated record sets of our business associates.

SECTION A: Individual requesting records amendment.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Identification Number: _____ Social Security Number: _____

SECTION B: To the individual—Please read the following and complete the information requested.

You have the right to request that we amend your protected health information in designated record sets we or our business associates maintain. We may decline your request if the information is not part of these designated record sets, we did not create the information, we believe the information is complete and accurate, or the information is psychotherapy notes, compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding, or not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a). To exercise your right to request amendment, please complete this Section B.

Please specify the records you wish to amend and the amendments you wish to make:

Please state the reasons for the amendments:

Please list the name and address of each person who you want us to notify of the amendment should we agree to make the amendment you request. You must provide us with a signed authorization for us to notify these persons. We can supply you with the appropriate authorization form.

INDIVIDUAL'S SIGNATURE.

Date: _____

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

Personal Representative's Name: _____

Relationship to Individual: _____

Send completed and signed form to:

Associated Benefits Corporation
Privacy Office
PO Box 71039
Des Moines, Iowa 50325-0039