DENTAL/VISION CONFIDENTIAL COMMUNICATIONS REQUEST FORM

Use this form to request that we communicate with you using a different means or location.

Your Current Information

Plan Type & ID Number

Member Name

Date of Birth

Address

Telephone Number

Your New Information

New Address

New Telephone Number

Reason for Request

D`YUgY`Wca d`YhY`h\ Y`Zc``ck]b[`fY[ UfX]b[ `mci f`WcbZ]XYbh]U`Wca a i b]WUh]cbg`fYei Ygh'

Will the failure to communicate your Protected Health Information through the means you have disclosed here endanger you? Yes No

G]][bUh i fY`UbX`5 W_bck `YX[a Ybh

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ÁÁunderstand that I @æç^Á@ Áã @Á[Á^ç[\^Á@ã Á^˘˘^• cÁby contacting the Aflac's third party administrator at the address below, and I understand that such revocation will apply only to information created or received after the date of revocation.

Date

Member or Legal Representative Signature ______________________________

Relationship to Member

Retain a copy for your records and return the original signed form to: Privacy Officer; Argus Dental & Vision, Inc.; 4919 West Laurel Street, Tampa, FL 33607.