

REQUEST FOR CORRECTION OR AMENDMENT OF PROTECTED HEALTH INFORMATION

Name Certificate/Policy Number

Address City State & Zip Code

I request the company amend the protected health information in its designated record set.

SPECIFIC STATEMENT OF AMENDMENT REQUEST

SPECIFIC REASON FOR AMENDMENT REQUEST

Please check all that apply:

POLICY SERVICE

Billing, coverage changes,
addition/deletion of family members, etc.

UNDERWRITING

Medical records, applications, personal
history telephone interviews, paramedical
exams, reinstatements, etc.

CLAIMS

Medical records, provider billing,
verification of benefits, etc.

This Date of
Service Only: _____

This Doctor or
Hospital Only: _____

I understand that if the protected health information was not created by the company, the company is not required to honor my request. For example, if the information I wish to amend is in a medical report created by my physician, I must ask the physician – not the company – to amend the report. I also understand that if the information is not available for my inspection, is not part of the plan's designated record set or is already accurate and complete, I cannot amend the information.

I understand that the company will respond to my request within 60 days.

Signature Date

RETURN TO: Morris Soler, Assistant Vice President, HIPAA Privacy Officer, 1 Moody Plaza,
Galveston, Texas 77550, (409)766-6420, HIPAA.Compliance.Officer@Anico.com.