Commonwealth of Massachusetts
Group Insurance Commission

CONFIDENTIAL COMMUNICATION REQUEST FORM

Name: _____ ***SS #:*** _____

Address:_____ **DOB:** _____

_____

_____

You or your Personal Representative have the right to request that you receive GIC communications) at an alternative location or by alternative means. You will be notified of GIC's decision in writing.

- **You or your Personal Representative are required to specify an alternative location or the means of communication you want the GIC to use.**
- **You must state that you could be endangered by not having confidential communications.**
- **If granted, this request may be revoked by GIC if the request becomes unreasonable. Written notice of the revocation will be provided to individuals and their Personal Representatives by GIC. The revocation will be effective after such notice is given.**
- **If you wish to request similar arrangements with your benefit plans or GIC coordinator, you must contact them directly to make your request.**

I am asking GIC to communicate with me using the following manner (specify location or manner of communication):_____

_____

_____

_____ _____
Signature of individual/ personal representative Date

_____
Print name

Indicate relationship of person signing this form to the enrollee

☐ Person signing is individual
☐ Person signing is the Personal Representative authorized to make medical decisions for the individual
Type of authority (e.g., court appointed, custodial parent) _____

_____

For GIC Use
Approved: ☐ Denied: ☐
ATTACH TO GIC RESPONSE TO REQUEST AND FILE IN MEMBER'S RECORD

Reviewer: _____ **Title**: _____ **Date**: _____