



You have the right to request that Guardian communicate with you about your health, payment for health care, and other information in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We will accommodate all reasonable requests made in writing that clearly state that your life could be endangered by the current disclosure method of all or part of your PHI.

**Member Information: (Individual requesting their information by an alternative means or at an alternative location)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(First, Middle, Last) (Month/Day/Year)

Address: \_\_\_\_\_  
City State Zip Code

Telephone Number: \_\_\_\_\_  
(including area code)

Employer Name: \_\_\_\_\_ Group Plan #: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Last Four Digits of Social Security Number: \_\_\_\_\_

If you wish us to contact you at an address or phone number other than your home address or home telephone, please provide the information that you would like us to use:

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Alternative Telephone Number: ( ) \_\_\_\_\_ - \_\_\_\_\_

Describe in as much detail as possible any other alternative means you request we use in communicating with you or any other alternative location not detailed above:

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

Please describe the reason for the request:

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

Print Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

If you are an authorized representative (other than a parent of a minor child), you will need to provide documentation or an explanation of your authority to act for the member (e.g., Health Care Power of Attorney).

Please send this form to: The Guardian Life Insurance  
Company of America  
Group Quality Assurance  
P.O. Box 2457  
Spokane, WA 99210-2457