



CALIFORNIA FIELD IRONWORKERS TRUST FUNDS

Pension Trust • Welfare Plan • Vacation Trust
Apprenticeship Training & Journeyman
Retraining Fund • Annuity Trust

POLICY & PROCEDURE PARTICIPANT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Effective Date:

Section: Privacy

Reviewed By: _____ Reviewed Date: _____

POLICY

Participants have the right to request restrictions on how and where their Protected Health Information ("PHI") is communicated.

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PROCEDURE

- IEBC requires participants who desire their PHI to be communicated in an alternative manner or location than the Health Plan would otherwise use, to specify the alternative location or other method of communication.
- IEBC requires that the participant clearly state that the restriction is necessary to prevent a disclosure that could endanger the participant.
- IEBC does not refuse to accommodate such requests unless the request imposes an unreasonable administrative burden.
- The participant may request confidential communication at any time.
- The request must be made in writing to Gloria Loot, Benefits Manager, (800) 527-4613; or 131 N. El Molino Avenue, Suite 330, Pasadena, CA 91101.
- Written documentation of the participant's request, if granted, will be placed in the participant's record(s).



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Participant or Beneficiary Request for Confidential Communications

* * * * *

Participant or Beneficiary Name: _____ Birth Date: ___/___/___

Address: _____

Home Telephone Number: _____ Email: _____

Participant or Beneficiary Identification Number and/or Social Security Number: _____

I, _____, am requesting that IEBC communicate with me in the alternative manner and/or location described below regarding my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996). Such restriction is necessary to prevent a disclosure that could endanger me. I understand that IEBC may deny this request if it imposes an unreasonable administrative burden.

Description of the Health Information that must be Communicated Confidentially: The following is a description of the specific health information to which this request applies:

Alternative Manner and/or Location: I request that IEBC only communicate with me in the following manner and/or at the location described below:

By signing this form, I am confirming that it accurately reflects my wishes.

Signature: _____ Date: _____

If signed by personal representative;
Name of Personal Representative: _____

Relationship to participant or beneficiary or nature of authority: _____

Signature of Personal Representative

Date

SUBMITTED COMPLETED FORM TO:

**Privacy Official
131 N. El Molino Avenue, Suite 330
Pasadena, CA 91101-1878**