SEAFARERS HEALTH AND BENEFITS PLAN

5201 Auth Way
Camp Springs, Maryland 20746-4275
(301) 899-0675

Margaret R. Bowen
Administrator

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Participant Name: _____ Date of Birth: ____/____/____

Social Security # xxx-xx-_____

Address: _____

_____

_____

Daytime Phone Number: _____ Evening Phone Number: _____

I am requesting that the Plan amend the following protected health information:

_____

_____

_____

I am requesting that the Plan amend this information in the following way:

_____

_____

_____

I understand that if the information that I am requesting be amended was not created by the Plan, the Plan may deny this request.

I also understand that if the information that I am requesting be amended is determined by the Plan to be accurate and complete, the Plan may deny this request.

I further understand that the Plan may deny my request if the information that I am requesting be amended is not contained in the designated record set or if I do not have the right to amend the information.

Signature of Participant: _____ Date____/____/____

If signed by personal representative:

Name of personal representative: _____

Relationship to participant or nature of authority: _____

_____ ____/____/____

Signature of Personal Representative Date