Cancel confidential communication

Wellmark Advantage Health Plan

Wellmark Advantage Health Plan, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.

Use this form if you currently have confidential communication in place and no longer need it.

A Please identify the MEMBER who has confidential communication

Member name _____ **Date of birth** _____

Member ID (number on ID card beginning with 1 to 3 letters) _____

B Current address of SUBSCRIBER *(Complete using the enrollment information we have on record).*

Subscriber Address _____

City _____ **State** _____ **ZIP** _____

C Address/telephone number CURRENTLY being used for confidential communication

Member Address _____

City _____ **State** _____ **ZIP** _____

In care of: *(optional)* _____

Telephone number _____

D Signature *(Sign and date the appropriate line)*

I no longer need Wellmark Advantage Health Plan to communicate with me about my protected health information by an alternate method, such as a different address or telephone number that I may have provided. I understand that this does not affect actions taken before Wellmark Advantage Health Plan received this signed document.

I also understand that when confidential communication is canceled, Wellmark Advantage Health Plan will:

- Mail communications containing my protected health information to the address of the subscriber (the person whose name appears on my ID card)
- Rely on telephone information in my membership records when contacting me by telephone
- Restore access to my account on www.WellmarkAdvantageHealthPlan.com

Note: Complete form by signing in EITHER Section 1 or Section 2 on the following page.

Continued on following page.

1 If you are the MEMBER requesting confidential communication

SIGN HERE _____ Date _____

2 If you are the member's PERSONAL REPRESENTATIVE

Please provide your name, sign and date. Check the box that best describes your relationship to the member. If it is not already on file, **attach proof of your relationship to the member**. Parents do not need to attach proof.

Representative's full name _____

SIGN HERE _____ Date _____

- ☐ Parent of minor (younger than 18) child
- ☐ Legal guardian: *Attach guardianship documentation (must have a court's stamp and signature).*
- ☐ Power of attorney: *Attach power of attorney (**must include** authorization of the release of healthcare information).*
- ☐ Executor: *Attach letter of appointment of executorship (must have a court's stamp and signature).*
- ☐ Patient Advocate: *Attach Designation of Patient Advocate form, signed by member.*

Please mail completed form (and documentation if needed) to:

Customer Individual Rights Unit
600 East Lafayette, MC 1620
Detroit, MI 48226-2998

or fax to 1-877-522-4767.