CONFIDENTIAL COMMUNICATION REQUEST FORM

Vision Insurance

You may use this form if you are covered by insurance and wish to make a reasonable request to receive communications from EyeMed Vision Care LLC by alternative means or at alternative locations if disclosing claim or other related information could endanger you. For purposes of this form "you", "your" or "another person" is the "Covered Individual".

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1. Covered Individual(s) Requesting Confidential Communications

First and Last Name(s): _____

Current Address: _____

Date of Birth (*MM/DD/YYYY*): _____ Member I.D./Contract number: _____

Primary Insured/Subscriber First and Last Name: _____

Relationship to Primary Insured/Subscriber: _____

2. Please read the following and complete the information requested.

You have the right to make a reasonable request that you receive communications of claim or other related information from us by alternative means or at alternative locations if disclosing the claim or other related information could endanger you. Claim information includes all claim or billing information relating specifically to you, including your name, address, any services received, and the name and address of the provider of any services (such as your doctor). Your request will remain in effect until you revoke the request.

I, the Covered Individual, request that EyeMed Vision Care, on behalf of insurance company, send communications of claim or other related information to me by the following alternative means or at the following alternative locations because disclosing the claim-related information could endanger me:

In care of: _____

(If you are using someone else's address, then enter his or her name here)

Alternative Address: _____

Alternative Phone Number: _____ Email Address (optional): _____

Signature: _____

(*Covered Individual/Parent/Guardian/Legal Representative*)

Date: _____

If the Covered Individual is a minor (under 18) or is otherwise incapacitated and the person making this request is the parent, guardian or other legal representative, please provide:

Parent/Guardian/Legal Representative's Name: _____

Relationship to Covered Individual: _____

Parent/Guardian/Legal Representative's Phone Number: _____