The Prudential Insurance Company of America
As administered by illumifin Corporation

REQUEST FOR PRIVACY PROTECTION/CONFIDENTIAL COMMUNICATIONS

Purpose: This form has been sent to you per your request to implement restriction of uses and disclosures of Protected Health Information and or to receive Confidential Communications at an alternative location. Please answer all of the questions below, sign, where applicable, and mail to the address indicated below.

I. Policyholder Information - Policyholder Name**:** _____

Policy Number: _____ Policyholder Birth Date: _____

Current Address: _____
(City, State, Zip Code)

Telephone Number: Daytime: _____ Evening: _____

II. Requestor Information - Your Name: _____

Your relationship to the policyholder (check where applicable):

☐ Policyholder ☐ Spouse* ☐ Child* ☐ Legal Representative** ☐ Other: _____

*Please provide your birth date if you are a spouse or child of the policyholder: _____

*** Supporting documentation that you are the properly designated legal representative of the party in question is required in order to process your request on behalf of that individual.*

III. Request Type:
You wish to (check the applicable section):

☐ Restrict the Uses and Disclosures of Protected Health Information:
This option restricts illumifin Corporation from using or disclosing protected health information about its Prudential policyholders to carry out treatment, payment, or health care operations. illumifin Corporation is not required to agree to a restriction. Illumifin Corporation may use or disclose Protected Health Information where required by the HIPAA Privacy Rules, (available online at http://www.hhs.gov/ocr/privacy/hipaa/administrative/index.html).

☐ Receive Confidential Communications about my Protected Health Information at the following address:
An alternate address is required in the lines below if you wish to receive Confidential Communications of Protected Health Information. If no address is provided, the form will be returned as incomplete. An individual may request this option only when the disclosure of all or part of the Protected Health Information may endanger that person. Please note that once the request for Confidential Communications becomes effective, the requestor may be responsible for any out of pocket expenses incurred. Furthermore, all payments under the policy will continue to be paid to the policyholder.

_____
(Street Address/P.O. Box)

_____
(City, State, Zip Code)

IV. Signature:
By affixing my signature below, I understand that illumifin Corporation is not required to restrict the uses and disclosures of Protected Health Information. I may, at any time, request, in writing, that the restriction may be terminated. I understand that all payments under the policy will continue to be paid to the policyholder. I will receive a confirmation letter from illumifin Corporation once my request for Privacy Protection and or Confidential Communications have been executed.

_____ _____ _____
Requestor's Signature Requestor's Printed Name Date

Submit the completed form to:
The Prudential Insurance Company of America
as administered by illumifin Corporation
ATTN: Compliance Support Services ✧ Post Office Box 64372, St. Paul, MN 55164-0372