MAILING ADDRESS
PO Box 2022
Carmel, IN 46032-2022

Fax: (800) 757-6324

CONFIDENTIAL INSURANCE COMMUNICATION REQUEST FORM

This form is for use by a person who is covered by insurance and wishes to make a reasonable request to receive communications of insurance claim-related information from CNO Services, LLC* by alternative means or at alternative locations if disclosing claim-related information could endanger the person.

This form may also be used to terminate a previously granted request for confidential communications.

SECTION A: Confidential Communication Request or Termination of Previous Request

Please choose one of the following:

☐ Initial Request – This form is an initial Confidential Insurance Communication Request (Complete the entire form)

☐ Terminate a Previous Request – This form is terminating a previously approved Confidential Communication Request. (Complete sections A and B only.) Future correspondence will be sent to the address of record.

_____
Signature

_____
Date: month/day/year

SECTION B: Covered individual requesting confidential communication:

Name: _____ Policy Nos.: _____
(List all applicable policies)

Birth Date: _____

Relationship to Policy Owner or Primary Insured: _____

SECTION C: To the covered individual – please read the following and complete the information requested.

You have the right to make a reasonable request that you receive communications of claim-related information from us by alternative means or at alternative locations if disclosing the claim-related information could endanger you. "Claim-related information" means 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.

As a covered individual, I request that communications of claim-related information are provided to me by the following alternative means or at the following alternative locations because disclosing the claim-related information at the policy's address of record 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: _____

Signature: _____ Date: _____

SECTION D: Parents, Guardians, or Legal Representatives

If the covered individual is a child younger than 18-years-old and the person making this request is the child's parent or guardian, then provide:

Parent or Guardian's Name: _____

Relationship to Covered Individual: _____

If a legal representative (such as a Power-of-Attorney) is making this request on behalf of the covered individual, then provide written evidence of such authority in addition to the following:

Legal Representative's Name: _____

Relationship to Covered Individual: _____

Organization or Firm Name: _____

Address: _____

Phone Number: _____

*CNO Services, LLC administers policies on behalf of one or more of the following insurance companies, Bankers Life and Casualty Company, Bankers Conseco Life Insurance Company * [*domiciled in and licensed in the State of New York], Colonial Penn Life Insurance Company, Conseco Life Insurance Company, Washington National Insurance Company.