



Michigan Conference of Teamsters Welfare Fund Individual Request to Amend Protected Health Information

Section #1: Individual Information

I certify that I am (check all that apply):

- A participant (employee/retiree)
- A participant's spouse or surviving spouse
- A non-spousal dependent of a participant
- A personal representative*

Name of Participant: _____
(print name)

Participant's Contract Number: _____ - _____ - _____ Participant's Birth Date: ____/____/____
MM / DD / YR

You can contact me at:

Home Telephone Number: _____ E-mail: _____

Work Telephone Number: _____

I am requesting an amendment to the health information for (check only one):

- Myself (print name) _____
- My dependent minor child (print name) _____
- A covered individual for whom I am the personal representative* (print name) _____

**Note: If you are a personal representative of the individual and you are completing this form on behalf of the individual, you must complete the personal representative area found in Section #3. Personal representative means a person with legal authority (under State or applicable law) to act on behalf of the individual in making health care decisions.*

Section #2: Request for Amendment

I, _____ (print name), hereby request an amendment to the health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) for the identified individual identified in Section #1. I understand that the Michigan Conference of Teamsters Welfare Fund (the Fund) **may not** grant this request for amendment if the information: 1) was not created by the Fund; 2) is accurate and complete; 3) is not part of the record requested for amendment; and/or, 4) includes information that I am not permitted to change.



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Please make the following amendment(s) to the health information for the individual identified in Section #1 as described: (Note: Attach copies of documentation to support your claim for amendment.)

I request that the amendment(s) as described be made to the health information contained in the following records (check all that apply):

- enrollment
- contribution payment
- case or medical management
- claims, billing and EOB information relating to the following service or claim: (specify date of service and/or medical condition)

- all of the above
- other (please specify) _____

I, _____ (print name), have reviewed this form and understand its contents. By signing this form, I am confirming that it accurately reflects my wishes.

Signature _____/_____/_____
MM DD YY Date of Signature

Address: _____

Section #3: Personal Representative

If signed by a personal representative, complete the following:

Name of personal representative: _____
(print name)

Name of individual you are representing: _____
(print name)



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Relationship to individual or nature of authority (e.g., parent of an unemancipated minor, unlimited guardian pursuant to letters of authority, personal representative pursuant to letters of authority, parent advocate pursuant to a health care power of attorney, other statutory authorization): _____

Note: You must provide valid and current proof of your legal relationship as a personal representative.

Personal Representative Contact Information

Address: _____

Home Telephone Number: _____ E-mail: _____

Work Telephone Number: _____

_____/_____/____ Date of Signature
Signature of Personal Representative MM DD YR

Section #4: Submission Instructions

Submit Form to: Privacy Officer
Michigan Conference of Teamsters Welfare Fund
2700 Trumbull Avenue
Detroit, MI 48216