30-30 47th Avenue, Suite 625
Long Island City, NY 11101
Phone 718-248-8000
Fax 800-584-9303
www.nationalbenefitlife.com

NATIONAL BENEFIT LIFE INSURANCE COMPANY

CONFIDENTIAL 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 National Benefit Life Insurance Company by alternative means or at alternative locations if disclosing claim-related information could endanger the person.

Send completed form to:
National Benefit Life Insurance Co.
30-30 47th Avenue, Suite 625, Long Island City, NY 11101
Fax 800-584-9303 or email customerservice@nationalbenefitlife.com

SECTION A – Covered individual requesting confidential communication

Name _____ SSN _____ Policy / Claim# _____

Birth Date (mm/dd/yyyy) _____ Primary Insured _____

Current Address _____

Employer _____

SECTION B – 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 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 National Benefit Life Insurance Company send communications of claim-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 _____ Alternative Email Address _____

Signature _____ Date _____

SECTION C – 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 please provide this information.

Parent or Guardian's Name _____ Relationship to Covered Individual _____

If a legal representative, such as an attorney, is making this request on behalf of the covered individual, then please provide this information.

Legal Representative's Name _____ Relationship to Covered Individual _____

Organization or Firm Name _____

Business Address _____

Business Phone Number _____ Business E-mail Address _____

NYS Domestic Violence Hotline and Sexual Violence Hotline number is 800-942-6906 (Spanish 800-942-6908).