REQUEST FOR TERMINATION OF CONFIDENTIAL COMMUNICATIONS

Instructions: To request termination of confidential communications, please complete the information below, sign in the space provided and return to: Braven Health, Attn: HIPAA Team, P.O. Box 1458, Newark, New Jersey 07101-1458 or via fax at 973-274-2358.

I, ____, request termination of confidential communication of my private information by Braven Health and its business associates, including termination of the password protection that had been established for this purpose. I understand this request applies only to communications from Braven Health to me. I also understand this will be in effect upon receipt and processing by Braven Health of this written request.

Print Name: ____

Signature*: ____ Date: _____________/_____________/_____________

Member's Name: ____

Member's Date of Birth: ________/________/________

Subscriber Name: ___________________________________ Subscriber Identification #: _______________________

Alternate address to be removed: ____

City: ____ State: _____________ Zip: _______________

Password to be removed: ____________________________ (If you are unable recall the password please leave blank)..

* Only the member or the personal representative who originally set up the confidential communications may terminate the agreement.

Mail form to the following address or via fax at 973-274-2358:

Braven Health
Attn: HIPAA Team
P.O. Box 1458
Newark, NJ 07101-1458

Products are provided by Braven Health, an independent licensee of the Blue Cross Blue Shield Association.