

Request for Amendment of Records

Instructions:

Use this form to request a change to your personal information that we maintain, if you think we have incorrect or incomplete information (other than as listed below). For instance, if you think information in a case management record is incorrect, use this form to request a correction.

- Please **do not** fill out this form for the changes below. Instead, call Customer Service to tell us if:
 1. your current address is incorrect
 2. you or your dependents' names are spelled wrong
 3. you or your dependents' birth dates are incorrect.
- If you want us to send correspondence for one of your dependents to another address, that person needs to complete the Non-disclosure and Alternate Address Request Form and return it to us.
- If records from your health-care provider need to be corrected or changed, you need to contact him/her yourself.

Please complete the form and return it to the address shown. If you have questions on how to use this form, contact Customer Service.

In some cases, we may not be able to honor your request. For example, we cannot change information created by a health-care provider outside our company.

For details on your rights regarding your personal information that we maintain, see our Notice of Privacy Practices. You can find it on our Web site, or call Customer Service at the number on the back of your ID card for a paper copy.

Request for Amendment of Records

IDENTIFYING INFORMATION

Please provide the following details for the individual whose records you are requesting to be amended. **Please print clearly.**

IDENTITY of MEMBER

Birth date: _____

Member name: _____
First name M.I. Last name

Subscriber Name: _____
First name M.I. Last name

ID number: _____

IDENTITY of REQUESTOR (if other than member). Must be the member's parent, legal guardian or holder of power of attorney.

Requestor's name: _____
First name M.I. Last name

Relationship to member: _____
(If legal guardian or holder of a power of attorney, please attach legal documentation)

MAILING ADDRESS

Copies of records and other correspondence about this request should be mailed to the address listed below and addressed to the:

Member Parent, legal guardian or holder of power of attorney

Address: _____

City: _____ State: _____ ZIP: _____ Daytime phone number: () - _____

INFORMATION TO BE AMENDED

We can only amend records that were created by us. Requests to amend records created by provider(s) must be sent directly to them.

Describe the information in the records you want amended.

Dates of the record(s) to be amended. _____

What is the reason for making this request? _____

How is the record incorrect, incomplete, or outdated?

What should the record say to be more accurate or complete?

SIGNATURES AND MAILING REQUEST TO US

Signature of requestor: _____ Current date: _____

Printed name: _____

MAIL REQUEST TO: LifeWise Assurance Company, P.O. Box 91102, Seattle, WA 98111-9202

Please note: This request for amendment of records will be processed within 60 calendar days of receipt unless we notify you otherwise in writing.

Discrimination is Against the Law

LifeWise Assurance Company (LifeWise) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. LifeWise does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. LifeWise provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). LifeWise provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that LifeWise has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator – Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-6396, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@LifeWiseHealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-971-1491 (TTY: 711).

注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-971-1491 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-971-1491 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-971-1491 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-971-1491 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-971-1491 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-971-1491 (телетайп: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-971-1491 (TTY: 711)។

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。800-971-1491 (TTY:711) まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 800-971-1491 (መስማት ለተሳናቸው: 711)።

XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajjila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-971-1491 (TTY: 711).
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-971-1491 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-971-1491 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: 800-971-1491 (TTY: 711).

ໂປດອຸບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີຮັບໃຫ້ທ່ານ. ໂທສ 800-971-1491 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-971-1491 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-971-1491 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-971-1491 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-971-1491 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-971-1491 (TTY: 711).

توجه: اگر بہ زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-971-1491 (TTY: 711) تماس بگیرید.