



Request for Confidential and/or Alternative Communications of Protected Health Information

Complete, sign, date and mail or fax this form to:

Privacy Office, Sun Life Financial, P.O. Box 419052, Kansas City, MO 64141-6052

Fax no. 816.881.8508

Please complete the following:

Insured/Member name _____	Last four of SSN _____
If request for dependent, give name and relationship to insured/member _____	
Street address _____	Date of birth _____
City/State/Zip _____	Day phone _____
Employer/Policyholder name _____	Policy/cert. no. or member ID _____

Union Security Insurance Company, Union Security Life Insurance Company of New York or an affiliated prepaid dental company ("the Companies") are required to provide you with the opportunity to request confidential and/or alternative communications. You may request that the Companies communicate with you by an alternative means or at an alternative location, if you can document that your life would be endangered if the Companies communicate with you as we currently do.

The Companies are not required by law to agree to your request for confidential and/or alternative communications.

Please complete the following and include any documentation that supports that your life is endangered, such as Restraining order, court-ordered judgment, etc., if applicable.

1. The Companies current method of communicating with me could endanger my life in the following way(s):

2. I request that the Companies only communicate with me in the following manner:

3. I request that the Companies only communicate with me at this location:

We will notify you in writing of the approval or denial of your request.

If your request is approved, we will provide you with the date your request will be effective.

By signing this form, I understand that the Companies may deny this request and that I am confirming that it accurately reflects my wishes.

Signature of Requestor _____ Date _____

If signed by a Personal Representative:

Name of Personal Representative _____ Phone no. _____

Relationship to individual or nature of authority _____

Signature of Personal Representative _____ Date _____

(If you are the Personal Representative, other than a parent or legal guardian, please attach a copy of any documents verifying your position as Personal Representative.)

Please submit a separate form for each individual.

Insurance products are underwritten by Union Security Insurance Company (USIC) (Kansas City, MO) and administered by Sun Life Assurance Company of Canada (SLOC) (Wellesley Hills, MA) in all states except New York. Prepaid dental products are provided by USIC and are administered by SLOC, and are provided by prepaid dental companies affiliated with SLOC in certain states except New York. Prepaid dental companies are Denticare of Alabama, Inc., United Dental Care of Arizona, Inc., UDC Dental California, Inc., United Dental Care of Colorado, Inc., Union Security DentalCare of Georgia, Inc., United Dental Care of Michigan, Inc., United Dental Care of Missouri, Inc., Union Security DentalCare of New Jersey, Inc., United Dental Care of New Mexico, Inc., UDC Ohio, Inc., United Dental Care of Texas, Inc., and United Dental Care of Utah, Inc. In New York, insurance products and prepaid dental products are underwritten or provided by Union Security Life Insurance Company of New York (Fayetteville, NY) and administered by Sun Life and Health Insurance Company (U.S.) (Lansing, MI).