



Restriction Request Form

Use this form to request restrictions on Dearborn National Life Insurance Company's use or disclosure of your Protected Health Information (PHI) for payment or health care operations purposes. You may also use this form to terminate a previously granted request for restriction. **If you need assistance in completing this form, please call the Customer Service number listed on the back of your Member Identification Card.**

WHEN COMPLETED AND SIGNED PLEASE MAIL TO: **Privacy Coordinator
Dearborn Life Insurance Company
701 E. 22nd St Ste 300
Lombard, IL 60148
Fax: 1-630-495-0575**

Section A: Restriction Request or Termination

Is this form being used to terminate a previously approved request for Restriction? If "Yes", complete Section B, then proceed to Section D. If "No", then complete this form entirely.

- Yes**-Enter date to terminate previous request: _____
 No **Date: month/day/year**

Section B: The individual for whom restriction is being requested. Please complete the following:

Name **Group #** **Identification\Subscriber #**

Social Security Number **Date of Birth**

Address **City** **State** **ZIP**

Area Code & Telephone Number **E-mail address (if available)**

Section C: Please specify your Protected Health Information (PHI) that you want restricted:

Please state how you would like to restrict the use and disclosure of this information:



If this request is granted, please note the following:

1. The request will only apply to your current Group and Subscriber Numbers and benefits coverage. If your Group or Subscriber Numbers change, or your benefits coverage changes, you must submit a new Restriction Request for the new group/subscriber number or benefit coverage.
2. Dearborn National Life Insurance Company and its Business Associates are only responsible for the PHI that they release in accordance with your designation in Section C.

Section D: Signature – This document must be signed by the individual, parent of minor child or the individual’s Personal Representative.

I request that Dearborn National Life Insurance Company restrict the use or disclosure of my PHI as specified in Section C above. I understand that Dearborn National Life Insurance Company is under no obligation to agree to my request. I understand I will receive a written determination regarding my request. I understand that if I am signing on behalf of a minor child, this request will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

Signature of Individual or Individual’s Personal Representative

Date: month/day/year

Section E: If Section C is signed by a Personal Representative, please complete the information below:

If you are signing as a Power of Attorney, Legal Guardian, Executor, or Administrator, attach a copy of the Legal documents. You do NOT have to attach copies of these documents if they are already on file with Dearborn National Life Insurance Company.

Signature of Personal Representative

Relationship to Individual

Personal Representative’s Address

City

State

ZIP

Personal Representative’s Area Code & Telephone Number

Personal Representative’s E-mail address (if available)