Request to Amend or Correct 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 corrections or amendments to your protected health information. This applies only to the protected health information that the Companies create and maintain on your behalf, and if you believe something in that information is in error or needs to be amended. The Companies are not required to make the corrections or the amendments you request, but each request will be carefully reviewed and corrections and amendments will be made if warranted. **Please note that any change will be noted as an amendment or correction and the original document will not be revised.**

Please provide as much detail as possible, including a copy of the original unamended document, indicating the correction or amendment you seek to your protected health information. Be as specific as possible regarding the record type, the location, the date and the problems.

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Please provide the names and addresses of any person or entity that you believe relied on the incorrect information. If your request for amendment or correction is approved, we will provide the person and/or entity you have identified with a copy of the amended document.

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

By signing this form, 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).