# Request for Accounting of Disclosures 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 and the prepaid dental companies ("the Companies") are required to provide you with the opportunity to request a list of the disclosures made of your protected health information above and beyond the disclosures allowed by law. You may request a list of disclosures for any time period after April 14, 2003 (not to exceed a period of six years).

The Companies are not required by law to include any of the following disclosures of your protected health information in an accounting to you:

- Disclosures made pursuant to an authorization signed by you or your Personal Representative;
- Disclosures to carry out the Companies' treatment, payment and/or health care operations;
- Disclosures made to you or your Personal Representative;
- Disclosures made to persons involved in your care and/or payment or notification of next-of-kin or family members;
- Disclosures for national security or intelligence purposes;
- Disclosures to correctional institutions or law enforcement officials; and
- Disclosures that occurred prior to April 14, 2003.

I am asking that the Companies provide me with a list of disclosures made of my protected health information, above and beyond the disclosures allowed indicated above after April 14, 2003.

**If you request more than one accounting in any 12-month period,**
**you will be charged $25.00 for each subsequent accounting requested.**
**Please include your check with your request.**

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By signing this form, I am confirming that it accurately reflects my wishes.

Signature of Requestor _____ Date _____

**If signed by a Personal Representative:**
Printed 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).