REQUEST A COPY OF HEALTH AND WELFARE INFORMATION

Participant's Identification Number
or Social Security Number: ____

Participant's Name: ____

Your Name
(if you are not the Participant): ____

Your relationship to the Participant
(if you are not the Participant): ____

Please describe what specific health information you are requesting and for whom?

Name and address to which TeamCare should forward this information:

Today's date: ____________________ Your signature: ______________________________

Print Name: ______________________________

Please mail the completed form to: Privacy Officer
TeamCare
PO Box 5125
Des Plaines IL 60017-5125

Or fax to: 847-518-9789