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