COMPLAINT FORM

You should use this form if you believe that the Group Health Plan or its Business Associate has failed to comply with matters covered in its Notice of Privacy Practices or has violated the Privacy Rule. The Plan will not penalize or any other way retaliate against you for filing a complaint.

I. **Individual Data:**

Covered Person's Name: _____

Covered Person's Social Security Number: _____

Address: _____

Telephone No.: _____

II. Complaint:

A. What is the nature of your complaint? _____
_____
_____
_____
_____
_____
(Please describe the reasons for your complaint in as much detail as you can provide. For example, which provision in the Privacy Notice you believe that the Plan or its Business Associate has violated and how the Plan or its Business Associate may have committed the violation.)

B. When did the action causing the violation occur? _____
_____
_____

C. If relevant, identify any persons at the Plan's or Business Associate's organization that may have information about your complaint. _____
_____
_____

Upon completion of this form please return it to:

Robert J. Cox
4200 N. Kentucky Ave.
PO Box 4169
Evansville, IN 47724-0169

If you have any questions about this form or matters covered in the Plan's Notice of Privacy Practices, please contact the Plan's Privacy Officer at the above address or at (812) 424-5536 or 1-800-637-1731.

Signature: _____

Name of Individual: _____

Date: _____