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: ____________________________________________________________________________

HIPAA Form 6 (Complaint Form) Apr-04