EMPLOYEE GROUP INSURANCE
COMPLAINT FORM
CONCERNING PRIVACY OF PROTECTED HEALTH INFORMATION

PLEASE TYPE OR PRINT LEGIBLY IN BLUE OR BLACK INK.
THIS FORM MUST BE FULLY COMPLETED IN ORDER TO BE CONSIDERED AS A WRITTEN COMPLAINT. IN ADDITION, WE MAY NEED TO CONTACT YOU FOR ADDITIONAL INFORMATION.

Name: _____

Mailing Address: _____

Daytime phone where we can contact you (including area code): _____

E-mail address where we can contact you about this complaint: _____

If your complaint involves your enrollment in group coverage through Employee Group Insurance, please tell us the plan name and your member number: _____

_____

TELL US ABOUT YOUR COMPLAINT. Please be specific. Include the approximate date(s) of the occurrence(s), the kind(s) of Protected Health Information involved; identify the name, title, and if available phone number or e-mail of any University of Texas employees you think may have knowledge about your complaint; and anyone you want us to contact about your complaint. You may attach additional pages if necessary. Please bear in mind that we may need to request a signed Authorization from you in order to contact some individuals. Please enclose COPIES of any documents you wish to be considered in connection with your complaint. PLEASE DO NOT SEND ORIGINAL DOCUMENTS AS WE CANNOT RETURN THEM. PLEASE KEEP A COPY OF YOUR COMPLAINT FOR FUTURE REFERENCE IF POSSIBLE.

Signature: _____ Date: _____

If complaint is signed by a legal representative of the individual:

Printed name of legal representative: _____
Representative's authority to act for the individual: _____

If the complaint is signed by a legal representative of the individual, please note that we must verify that you are this individual's legal representative for purposes of filing this complaint. Please enclose any documents that support this authority (Power of Attorney, Court Order, etc). As this person's representative, can you be contacted at the address, e-mail or phone number listed above? If not, please provide us with your mailing address, e-mail address and phone number as well:

This form should be delivered in person, by U.S. mail, or by facsimile to the following:

ATTN:

Manager of Insurance Benefits/Contact Person
Employee Group Insurance
702 Colorado Street, Suite 6.600
Austin, Texas 78701
FAX Number 512/499-4620

For EGI Use Only

Person processing complaint _____

Date complaint logged _____

Log number _____

Action taken _____