# REQUEST FOR ACCOUNTING OF DISCLOSURES OF PHI

**I, ______________________________, an insured member of an Ameritas Life Insurance**
**(print name)**
**Corp./Ameritas Life Insurance Corp. of New York (collectively "Ameritas") dental and/or vision plan through ______________________________, hereby request an**
**(Employer or Group Name)**
**accounting of the disclosures of my PHI that have been made by Ameritas as described by the Ameritas Notice of Protected Health Information Privacy Practices ("Notice") for the period of time beginning on ________________________, 20___ and ending on _____________________, 20___.**

**I understand that certain disclosures are not accountable under applicable law, such as disclosures that relate to treatment, payment or healthcare operations, and that Ameritas will account for the disclosures described in the Notice as required by law.**

**Signature** ________________________________ **Date** __________________

**Address:**

______________________
______________________
______________________
______________________

**Please complete the above statement and return the completed information to:**

**Ameritas Group Privacy**
**PO BOX 82520**
**Lincoln NE 68521**
**402-309-2580 (Fax)**

**Ameritas will send a written confirmation when this request is received.**

Form PO-0002
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