Request to Amend Protected Health Information

Ameritas Life Insurance Corp., Ameritas Life Insurance Corp. of New York

Use this form to amend protected health information (PHI) maintained by Ameritas Life Insurance Corp. or Ameritas Life Insurance Corp. of New York. Once we make a decision about your request, we will send you or your authorized representative a letter explaining the decision.

1. Member/Insured Information

Last Name: _____ First: _____ M.I.: _____

Address: _____

City: _____ State: _____ ZIP: _____

Date of Birth: _____ Member ID: _____

2. Please read and complete the following:

You have the right to request that we amend your protected health information in the designated record set that we, or our business associates maintain. We may decline your request if we did not create the records; the records are not part of our designated record set; the law does not give you the right to access the records; or the records are complete and accurate.

Please indicate what PHI you believe to be inaccurate and/or incomplete and describe the error. Please attach a copy of the information you would like to amend:

_____

_____

_____

_____

Please specify the reasons for the requested amendment:

_____

_____

_____

_____

3. Please sign and date:

X _____ _____

Signature of patient/guardian/personal representative: Date

Legal relationship to Patient *(Must be completed if signed by guardian or personal representative):*

_____

Important: If legal documentation is not on file with Ameritas, the authorized representative, including the legal guardian, executor of an estate, or power of attorney, must attach a copy of legal documentation to this form.

4. Please mail or fax the completed form to:

Ameritas
Attn. Group Privacy
PO Box 82520
Lincoln, NE 68501-2520

402-309-2580 (fax)