American Specialty Health

REQUEST TO DELETE PERSONAL INFORMATION (PI)

Please read this Request to Delete form carefully and fill it out completely. Failure to fully complete all applicable sections of the form may result in the form being returned to you. Responses should be printed in spaces provided using blue or black ink.

RETURN THIS FORM TO:
Attn: Privacy Officer
American Specialty Health
10221 Wateridge Circle, San Diego, CA 92121
Tel: 1-877-427-4766; **Fax:** 1-877-414-2746; **Email:** HIPAA@ashn.com

Instructions for completion of this Form:

- **Member Information section** – provide all requested information concerning the member.
- **Request Details section** – choose from the items available and/or write in information if needed.
- **Acknowledgment & Signature section** – please sign, print your name, and date this form. If this request is being made by someone other than the member, you must complete the information below the Signature line, describe your authority to make this request on the member's behalf, and include copies of the supporting documentation.

MEMBER INFORMATION
Member Name:_____ Date of Birth:_____
Street Address[1]:_____
City:_____ State:_____ Zip:_____
Telephone:_____ Email[1]:_____

REQUEST DETAILS
I wish to exercise my Right to Know in relation to the following products (select all that apply):
☐ Active&Fit Direct
☐ Active&Fit
☐ ChooseHealthy
☐ Other (Specify_____)
☐ I hereby request American Specialty Health to delete my personal information from the following limited features:
Please describe:_____

Please note: some products offered by American Specialty Health are not subject to the CCPA because they are governed by the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), the Health Information Technology for Economic and Clinical Health Act (Public Law 111-5), Gramm-Leach-Bliley Act (Public Law 106-102), or the California Financial Information Privacy Act (Division 1.4 (commencing with Section 4050) of the Financial Code). For these products, rights under the CCPA may not apply.

Acknowledgment & Signature

In signing this form, I understand that:

- American Specialty Health (ASH) will respond within 45 days of receiving this request.
- If ASH approves this request, ASH will permanently delete your personal information, de-identify your personal information, or aggregate your personal information, in whole or in part, and inform me when the change is completed.
- ASH may deny this request in writing if ASH is unable to verify the request based on information provided, if the form is submitted incorrectly for processing, or if ASH requires the use of your information to provide services on your behalf or for any other acceptable business purposes.

Signature _____ **Date** _____

Printed Name_____

Relationship to Member: ☐ **Self** ☐ **Other (complete information below)**

If this request is being made by an individual other than the member, please complete the information below, describe your authority to make this request on the member's behalf and include copies of supporting documentation.

Name_____

Street Address_____

City_____**State**_____**ZIP** _____

Telephone_____

Description of Representative's Authority to Act/Relationship to Member (choose one):

- ☐ Member is a minor and I am the member's parent or legal guardian.
- ☐ Member is deceased and I am the member's surviving spouse or next of kin, the executor/administrator of the member's estate, hold durable power of attorney, or
- ☐ I am otherwise legally authorized to act on behalf of a deceased member or the member's estate (please attach necessary documentation).
- ☐ I am the member's agent, as designated in the member's Durable Power of Attorney (please attach necessary documentation).
- ☐ Other (please describe and attach necessary documentation):_____
  _____

1 This information will be used to respond to your request. If different than the information linked to your account, please specify.