

Privacy Complaint Form

You should use this form if you believe that the Group Health Plan (“GHP”) has failed to comply with matters covered in its Notice of Privacy Practices or has failed to comply with its privacy policies as required by Standards for the Privacy of Individually Identifiable Health Information (often called the “HIPAA Privacy Rule”). The Group Health Plan will not penalize or in any way retaliate against you for filing a complaint.

INDIVIDUAL DATA:

Individual’s Name: _____

Group Health Plan ID #: _____

Address: _____

Telephone #: _____

COMPLAINT:

What is the nature of your complaint:

(Please describe the reasons for your complaint in as much detail as possible)

When did the action causing your complaint occur?

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE PRIVACY OFFICER AT (800) 223-9941.

You certify that the statements made in this complaint are true and correct to the best of your information and belief.

Name of Individual (Please Print) _____

Signature: _____

Date: _____

Upon Completion of this form please return it to:

**Privacy Officer
Commerce Benefits Group
PO Box 900
Elyria, OH 44036**