

# REQUEST TO TERMINATE CONFIDENTIAL COMMUNICATIONS

Read instructions on Page 2 before completing this form. **ALL FIELDS MUST BE COMPLETED.** A separate form is required for each member on the policy, as applicable. Please print all information legibly, except where signature is required.

To request the termination of a confidential communications that was created or exists for you, please complete the information below, sign in the space provided and return to: Horizon NJ Health, Attn: HIPAA Team, 1700 American Blvd. Pennington, NJ 08543 or via fax at **1-609-538-1574**.

## SECTION A - MEMBER INFORMATION

1. Member's name: \_\_\_\_\_ 2. Date of Birth: \_\_\_\_\_  
3. Subscriber's Name: \_\_\_\_\_  
4. Horizon NJ Health Member ID#: \_\_\_\_\_  
5. Address: \_\_\_\_\_

## SECTION B - ALTERNATE CONTACT INFORMATION TO REMOVE

Postal Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone #: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Password for oral communications with Horizon NJ Health: \_\_\_\_\_  
*(Leave blank if unable to recall the password)*

## TERMINATION OF CONFIDENTIAL COMMUNICATIONS

I, \_\_\_\_\_, request termination of confidential communication of my private information by Horizon NJ Health and its business associates, including termination of password protection that has been established for this purpose. I understand this request applies only to communications from Horizon NJ Health to me. I also understand this will be in effect upon receipt and processing by Horizon NJ Health of this written request.

Signature of Member / Requestor\* \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name \_\_\_\_\_

\*Only the member or the personal representative who originally set up the confidential communications may terminate the agreement.

Independent licensee of the Blue Cross and Blue Shield Association



Horizon NJ Health

## INSTRUCTIONS: REQUEST TO TERMINATE CONFIDENTIAL COMMUNICATIONS

### **General Instructions: All fields are required unless specified otherwise.**

This form must be completed when a member wishes to terminate an establish confidential communication with Horizon NJ Health. This form is not to be used to terminate an existing password.

**NOTE:** A separate form and documentation is required for each member on the coverage, as applicable.

### **Section A. Member Information**

This section requests information related to the member for which termination of confidential communications with Horizon NJ Health is requested. In the subscriber field, write the name of the policy holder. The policy holder is the individual who holds the insurance policy with Horizon NJ Health.

### **Section B. Alternate Contact Information to Remove**

Upon receipt of the completed request for termination of confidential communications, Horizon NJ Health will remove all alternate contact information that was established with the request for confidential communications, including the password. All future communications from Horizon NJ Health will be redirected to the subscriber's address on file.

### **Mail this form to:**

Horizon NJ Health  
Attn: HIPAA Team  
1700 American Blvd.  
Pennington, NJ 08543

### **or Fax to:**

**1-609-538-1574**

# Notice of Nondiscrimination

Horizon NJ Health complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

Horizon NJ Health provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information written in other languages.

## Contacting Member Services

Please call Member Services at **1-800-682-9090 (TTY 711)** or the phone number on the back of your member ID card, if you need the free aids and services noted above and for all other Member Services issues, including:

- Claim, benefits or enrollment inquiries
- Lost/stolen ID cards
- Address changes
- Any other inquiry related to your benefits or health plan

## Filing a Section 1557 Grievance

If you believe that Horizon NJ Health has failed to provide the free communication aids and services or discriminated on the basis of race, color, gender, national origin, age, or disability, you can file a discrimination complaint also known as a Section 1557 Grievance. Horizon NJ Health's Civil Rights Coordinator can be reached by calling the Member Services number on the back of your member ID card or by writing to the following address:

**Horizon NJ Health – Civil Rights Coordinator  
PO Box 10194  
Newark, NJ 07101**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

**Office for Civil Rights Headquarters  
U.S. Department of Health and Human Services 200 Independence Avenue, SW  
Room 509F, HHH Building Washington, D.C. 20201  
1-800-368-1019 or 1-800-537-7697 (TDD)**

OCR Complaint forms are available at [www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html).

Para ayuda en español, llame a **1-800-682-9090 (TTY 711)**.

# Multi-Language Insert

## Multi-language Interpreter Services

**ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-682-9090 (TTY 711). This document is also available in other languages, as well as other formats, such as large print and Braille.**

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-682-9090 (TTY 711)**.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-682-9090 (TTY 711)**。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

**1-800-682-9090 (TTY 711)** 번으로 전화해 주십시오.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.

Ligue para **1-800-682-9090 (TTY 711)**.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો

**1-800-682-9090 (TTY 711)**.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-800-682-9090 (TTY 711)**.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-682-9090 (TTY 711)**.

ملا : حوطة للغوية تترفاوا لباكلمن اج. تنك اذ ةقم ترتصل بارقم هاتفنا ركذا حدث للمان خف ، ، غمات المعداس **1-800-682-9090**  
(كبلاو صملام 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-682-9090 (TTY 711)**.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-682-9090 (телетайп 711)**.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.

Rele **1-800-682-9090 (TTY 711)**.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

**1-800-682-9090 (TTY 711)** पर कॉल करें।

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-682-9090 (TTY 711)**.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-682-9090 (ATS 711)**.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں

**1-800-682-9090 (TTY 711)**.